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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS

OBSTETRIC AND PEDIATRIC CARE OF WIVES AND INFANTS OF ENLISTED MEN: FEDERAL CHILDREN'S BUREAU PLAN

Important Statement of Michigan State Medical Society.—A letter dated July 28, 1943, on "Subject: Proposed Program of Obstetric-Pediatric Care for Wives of Enlisted Men," was addressed "To Every Member of the Michigan State Medical Society." In its last sentence it gave expression to this important statement:

"In its present form the [Federal Children's Bureau] plan (with payment direct to physicians) is definitely socialized medicine."

With that opinion, many members of the California Medical Association are in accord.

* * *

References to Informative Data.—CALIFORNIA AND WESTERN MEDICINE, in June (on pages 313-317) and July (on pages 1 and 79-88) has striven to present some of the informative letters and other data that led the California Medical Association Council not only to adopt its resolution concerning the Children's Bureau plan (see Item VI, on page 81, in July CALIFORNIA AND WESTERN MEDICINE), but to send to component county medical societies and their members the letter containing information that could serve as a guide for them in procedures which they, as individual physicians, might desire to take.

At the time of this writing, no new developments have come to the front, and therefore the Council's resolution and letter stand.

* * *

Text of the Michigan State Society Letter.—Because the Michigan letter referred to above so well states certain facts, further quotations are here given:

THE COUNCIL OF THE MICHIGAN STATE MEDICAL SOCIETY

1. *Opposes and disapproves* the plan for maternal and pediatric care to wives and infants of enlisted men as long as payments are made direct to physicians.

2. *Will approve* a plan *when* payment is made direct to the wives of enlisted men.

* * *

The attention of every member of the Michigan State Society is invited to the fact that if he signs application blanks for the plan *as offered to date* and participates in the program, it will:

1. Encourage the development of a poor quality of obstetric-pediatric care—a condition which always follows the operation of a regimented program (governmental).

2. Establish a precedent for further extension of governmental intrusion into the private practice of medicine. (Next may come eye, ear, nose, throat; then another, and, finally, all the sections including medicine and general surgery.)

3. Commit to this type of governmental program those 1,842 members of the Michigan profession who are in military service, without giving them the opportunity to express their opinion.

4. Open the door to governmental medical service for *all*, without economic distinction or determination of need.

5. Establish a fee schedule, which tends always toward revision downward. . . .

* * *

Any member who participates in the present governmental plan is doing so against the advice and opinion of the Council of the Michigan State Medical Society, the House of Delegates of the American Medical Association, and the Michigan State Advisory Council of Health. These groups have decided against the program of the U. S. Children's Bureau only after detailed study and consideration. By your action now you determine the future of the private practice of medicine.

* * *

Strange Inaction of the American Medical Association.—The serious implications as regards medical practice involved in the Federal Children's Bureau plan—and so well stated in the above excerpts from the Michigan letter of July 28—make it most difficult to understand why the national mouthpiece of organized medicine, *The Journal of the American Medical Association,* has made no editorial comment thereon!

The question is being asked, "Why the silence on this important issue when, on numerous subjects of lesser import, many press association dispatches emanate from the American Medical Association office in Chicago to appear in the newspapers throughout the length and breadth of the United States?"

* * *

Items Which Have Appeared to Date in the "Journal of the American Medical Association."—The following items have been noted in recent issues of *The Journal of the American Medical Association:*

1. A brief statement of news-item nature in the Miscellaneous Department (*The Journal of the American Medical Association,* issue of July 17, 1943, on page 816).

2. A one-page article by Dr. Edwin F. Daily, Director of the Division of Health Services, Children's Bureau, U. S. Department of Labor, in which the procedures indicated in the Children's Bureau Circular No. 13 of March 29, 1943, are outlined. (See June CALIFORNIA AND WESTERN MEDICINE, on page 315, and *The Journal of the American Medical Association,* issue of July 31, on page 945).

When these two items are scanned, and the letter of the Michigan State Medical Society also read, one cannot do otherwise than ask the question, "How has it come about that the American Medical Association—with all its special facilities and presumable representatives who are in contact with the higher powers in Washington, D. C.—has failed to inform the constituent state associations and their members, who make up also the membership of the American Medical Association, concerning the importance and significance of the impending Federal Children's Bureau plan?"

* * *

American Medical Association Fee Schedules as Quoted by Representatives of the Federal Children's Bureau.—In California, the fact that Dr. Edwin Daily of the Federal Children's Bureau was permitted to contact state medical associations, and get as far west as California without seeming contradiction on his statement that the initial proposed fee schedule of $35 to cover prenatal, confinement and postpartum care was based on some three hundred fee tables secured from the American Medical Association, continues to be a source of wonderment when California physicians discuss the matter. (See also on page 133.)

When on March 19 last the Federal Children's Bureau circular was issued, should not that have been sufficient notice to the national organization to promptly institute contacts with the proper governmental authorities so that authoritative fee schedule information from the American Medical Association headquarters would have been made available to the Washington officials?

* * *

American Medical Association House of Delegates and Newly Created Council on Medical Service and Public Relations.—On June 7, at the meeting of the American Medical Association House of Delegates, held this year in Chicago, Dr. John H. Fitzgibbon of Portland submitted the resolution on the Federal Children's Bureau plan previously adopted by the Pacific States Medical Executives' Conference at Portland on May 30, 1943 (see CALIFORNIA AND WESTERN MEDICINE, June, page 317, and *The Journal of the American Medical Association,* June 19, page 547). The American Medical Association House of Delegates accepted the basic provisions of that resolution (*The Journal of the American Medical Association,* June 26, page 621, and CALIFORNIA AND WESTERN MEDICINE, July, Item VII, page 82.) However, when the newly created American Medical Association "Council on Medical Service and Public Relations" held its first or organization meeting on July 21, it did not take action on the Federal Children's Bureau plan for obstetric-pediatric care. That American Medical Association Council will meet again in September. In the meantime, many things may happen.

* * *

Is Not "Time of the Essence"?—Are not the issues here discussed of sufficient importance to warrant action by the American Medical Association that would be more than what might be called "marking time"? If the American Medical Association had given early attention with action to the proposition and had sent adequate information to the constituent state associations, it is quite probable that other state units would have gone on record along lines that have been indicated by the

Michigan, Oregon, Ohio, and California State Medical Associations.

Is it fair to a small group of constituent state medical associations to make them carry on this battle against governmental intrusion into the domain of private medical practice? On a subject of national scope, is it not to be expected that the national organization will point the way?

* * *

How California Medical Association Members May Aid: Letter of President Schaupp.—In the meantime, it may be in order to print here, as a reminder to California Medical Association members, the letter of August 3 that was sent to the component county societies and members of the California Medical Association by Dr. Karl L. Schaupp, California Medical Association president, who is also chairman of the committee appointed by the Council to represent it in matters related to the Federal Children's Bureau plan.

In that communication, President Schaupp requests California Medical Association members to contact or write the California Senators and the district Congressmen, and point out ways of federal procedure that would make for a better quality of obstetric and pediatric care. The objective in this is to promote the conservation of those practices in scientific medicine that have been shown to be more acceptable to the citizens of the United States. In the light of experience, those procedures will also better safeguard and promote the public health interests of our nation.

President Schaupp's letter follows:

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

August 3, 1943.

The Component County Societies of the California Medical Association and Their Members,
Addressed

Dear Doctors:

The July issue of CALIFORNIA AND WESTERN MEDICINE presents a fairly complete survey of the Federal Children's Bureau Plan of Obstetric and Pediatric Care for the Wives and Infants of Enlisted Men (see first editorial on page 1, and the eighteen explanatory items commencing on page 79).

This letter is sent to suggest that your Society may wish to appoint a committee to call this subject to the attention of your local Congressman (whose address is given under Item XVI on page 85), before he returns to Washington.

Individual members of your County Society may also wish to write him. You are his constituents. He should be glad to receive your opinions.

It should be possible to enact legislation whereby federal money could be paid direct to the wives, they to choose their own physicians. Concerning this, see comment on page 85 (Michigan suggestions at bottom of left-hand column) and page 88 (Ohio plan).

The list of members of the Special California Medical Association Committee on the Federal Plan appeared on page 315 of the June issue of CALIFORNIA AND WESTERN MEDICINE.

Your aid in having your local Congressman acquire a better understanding of the issues at stake will be much appreciated.

Cordially yours,

SPECIAL CALIFORNIA MEDICAL ASSOCIATION COMMITTEE.

(Signed) Karl L. Schaupp, *Chairman.*
Donald G. Tollefson, *Vice-Chairman.*

COLLEAGUES IN MILITARY SERVICE: SOME OF THEIR PROBLEMS

Number of Available Physicians for Military and Civil Practice.—Many physicians who are in civilian practice have been so busy with extra work that they have had but little time for serious thought concerning the trials of colleagues who are in the armed services. Of the 180,000 doctors of medicine who are licensed in the United States it was estimated by the Federal Procurement and Assignment Service in December, 1942, that after some 42,000 physicians who are military officers had been deducted, a total of 94,500 effective physicians remained for civilian practice in the United States. About one-half of the physicians in military service are under 45 years in age. At the present time, for about every two physicians in civilian practice, there is one doctor of medicine in the armed forces. In the United States Army, the ratio of physicians to military personnel is about 1 to 150. The proportion in civilian practice varies from a prewar figure of one physician to about 1,022 persons, to a present wartime general average of 1 to 1,500; although in certain sparsely populated and also in some boom industrial areas, the ratio may run from one doctor of medicine to 3,000 persons or more—the 3,000 population ceiling being set as the dividing line where critical public health menaces may come into operation.

In the July issue of CALIFORNIA AND WESTERN MEDICINE, on page 78, appeared a War Manpower Commission directive dated June 7, 1943, in which it was stated that all physicians up to 45 years of age who were not actually essential in civilian life would be called upon to apply for commissions as medical officers. Referring to this directive, *The Journal of the American Medical Association,* in its issue of August 7, 1943, placed a colored box on the front-cover index with the words:

"6,000 MORE PHYSICIANS NEEDED NOW!"

The text of the editorial in that number is played up in full-page size and black-face type on page 1016, in order to emphasize the importance of the appeal. Those who have not acquainted themselves with the content of the directive, should not fail to do so. In this current issue of CALIFORNIA AND WESTERN MEDICINE, for excerpts therefrom, see page 124.

* * *

On Allocations and Responsibilities of Physicians in Military Service.—It is granted there is a considerable difference between the military ratio of one doctor of medicine to 150 military personnel, and the civilian figures of one physician to 1,500 persons, but that does not mean colleagues in military service do not have as great responsibilities. Certainly, in combat and certain foreign areas, surgeons attached to the Army, Navy, and Air Forces are being called on for services that far transcend anything experienced by colleagues who continue to carry on under peaceful home surroundings.

Which fact may be used to remind those of us who continue to care for the needs of civilians that

military colleagues in spare moments—whether in stations in the United States or overseas makes little difference—may be doing some serious thinking concerning the todays and tomorrows of medical practice.

Conversations with and communications received from medical officers reveal some of the things talked about in camps by the members of the medical staffs. It may be in order to mention some of these items, since they can be provocative of thought that may guide future action by those of us who remain at home.

* * *

Sacrifices by Physicians in Military Service.—Nearly all physicians who volunteered for service in the Army or Navy, or who entered because they came within the statutory age limits, left established private practices, in the development of which they had given their best efforts through varying periods of years. Since in medical practice so much of every physician's success is dependent upon his own personal qualities, it follows that when a civil practice is left by him it cannot be maintained in the same building or offices, as is possible with industrial and trade businesses. It is evident, therefore, that on entrance into military service, the physician places himself in a position—when and if ever he returns to private practice—which in most cases will mean that he will be obliged to start all over again; and almost under the same conditions as those which faced him when he left his interneship to take up his initial civil practice. In the meantime, he has grown older and such a prospect is less enticing than in days of youth.

Further, the situation as portrayed is almost always complicated by the fact that, with these thoughts of his future he must keep in mind always his responsibilities to his wife and children and their economic and welfare needs.

* * *

On Return to Civil Practice.—Military colleagues are quite aware that they have signed up for the "emergency." Even though war with the Axis powers may come to an end, such a date does not mean automatic and prompt return to civil practice. So long as the Commander-in-Chief deems the emergency to exist, and for some six months thereafter, medical officers may be retained in service. This element of the intangible and unknown does not always make for mental comfort.

Also, depending upon his assignments while he is in military service, the physician may feel himself slipping farther and farther away from the routine experiences of private practice. This, too, may lead to doubt on whether he will be able to again build up an adequate practice in limited time, and without going into financial debt.

* * *

Refresher Courses on Coming Out of Service.—The difference between military practice for men and civil practice for men, women, and children needs no comment. Military colleagues cannot escape thinking about the contrasts, however, and only too often are tempted to wonder how well fitted they will be to renew routines of healing-art procedure that were discarded when they took up military life.

It would be reassuring to them if they could know that when they again come out of service to resume the performance of civil work that short, intensive refresher courses, devised to give them an over-all insight into changes that may have developed in civil practice, would be available.

Here, then, is some planning for postwar days that must be gotten under way at an early day. It is gratifying to know that the four California medical schools, and the special California Medical Association Committee are giving this subject careful attention (see Council minutes, Item 11(I), in July CALIFORNIA AND WESTERN MEDICINE, on page 76).

* * *

Hospital Appointments.—Civil hospitals must be adequately staffed, of course. However, it must be appreciated that a situation wherein alien physicians and physically disabled graduates are now taking places as residents, which would have been filled by younger men who are at the present time in military service—and who are thus being denied the opportunity to better prepare themselves for their life work in general medicine and the specialties—is not a consoling thought to these younger colleagues. The above is mentioned because many military colleagues feel that these facts should be kept in mind by hospital authorities, and that the necessities rather than the luxuries of residencies is what should be the goal of hospital maintenance. There should be no neglect to civilians, but, on the other hand, the obligations to military colleagues should not be forgotten.

* * *

American Medical Association Fellowship Standing.—The financial sacrifice made by a physician who enters military service needs no elaboration. It comprehends something more than the salary received by the medical officer. His station in civil life required the maintenance of certain standards, so that many officers find their salaries insufficient to cover the established home needs of their families. Hence, expenditures of money must be scrutinized in order that loved ones be not made to suffer.

Therefore, when a statement for eight dollars is received by a military colleague who has maintained American Medical Association Fellowship, it is not surprising that he is apt to wonder on the extent to which Organized Medicine appreciates his service to our country. In other words, in all the beautiful sentiments expressed, how much is real and how much, mere lip appreciation?

With the onset of war the California Medical Association met its obligation in this by transferring from its general funds the money necessary to cover the annual assessments, thus exempting these military members from the payment of dues and maintaining by this procedure their active membership in both the California and American Medical Associations.

It is to be hoped that, at the next session of the American Medical Association House of Delegates steps will be taken to bring about the adoption of a suitable by-law that will reëstablish and continue to maintain American Medical Association Fellowship for all American Medical Association members who were Fellows at the time of their entrance into military service. Constituent state associations have taken analogous action in regard to state association membership. Why should not the wealthy national organization bring similar procedures into being as regards American Medical Association Fellowship?

* * *

On Letters to Military Colleagues.—Several medical officers have called attention to letters from colleagues in civil practice who complain, and make such statements as "The large amount of extra income in civil practice hardly compensates for the heavy work and hours involved." The expression of such sentiments is not of a nature to receive kindly reception by the medical officers who have given up all in order to make possible the maintenance of civil practice and the freedoms we hold dear. In other words, a letter should not particularize overmuch the "hardships of colleagues in civil practice." That line of thought is better omitted in letters to friends in the Services.

* * *

On Salaries of Medical Officers.—One suggestion received had to do with salaries of medical officers. The point was made that the training and responsibilities of medical officers are such that, in order to be in fair proportion to what civilians in wartime work receive in the way of compensation—and also because of the uncertainty of promotion to higher rank with increase of pay, that the initial commission for all medical men who voluntarily enter military service should not be less than that of a captaincy in the Army. Whether any steps can be taken to bring about a betterment in this direction is not known. The subject should be worthy of study.

* * *

Ohio State Medical Society's Card.—At county society meetings and in staff rooms there has been much conversation on our obligations to our military colleagues. It is agreeed, both as regards professional and lay circles, there is well-defined recognition of the splendid services rendered to the armed forces by the medical profession. This is shown, for instance, by the excerpts from newspaper editorials which have appeared since July, 1942, in issues of CALIFORNIA AND WESTERN MEDICINE (in the Miscellany Department, under the caption "Doctors of Medicine as Others See Them." In this issue, see page 146.)

The Ohio State Medical Society has gone farther, however, and in its official journal recently inserted a full-page size and beautifully illuminated card for placement in the reception rooms of members who remain in civil practice.

Its text is worthy of consideration, and is given here to conclude these comments:

OUR OBLIGATION

Perhaps the physician who has been providing you with medical services is one of the many Ohio physicians now on duty with the Army and Navy.

While he is making this sacrifice for you and me, you may count on those of us who remain on the home front to do our utmost to meet your medical needs.

However, it is my sincere hope that when your doctor returns, you will resume your former relationship with him.

....., M. D.

WAGNER-MURRAY-DINGELL SOCIAL SECURITY OR "CRADLE TO GRAVE" BILL (S. 1161; H. R. 2861): ITS PLACE IN RELATION TO MEDICAL PRACTICE

Some of the Background of S. 1161 and H. R. 2861.—Much has been written in recent weeks concerning the revised Social Security plan introduced as a Senate bill (S. 1161) on June 3 by Senators Robert F. Wagner (D., N. Y.) and James E. Murray (D., Mont.), and submitted as a companion House Resolution (H. R. 2861) on the same day by Congressman John D. Dingell (D., Mich.). An alias for this proposed "Cradle to the Grave" law is "the A. F. L.-C. I. O. bill," the measure seemingly having the sponsorship of the executive bodies of those labor organizations.

The bill is a follow-up or descendant of other measures introduced in recent years by Senator Wagner, but it also has close relationship to propositions put forth in an almost 500,000 word report by President Franklin Delano Roosevelt's "National Resources Planning Board," of which board his own uncle, Mr. Delano, is chairman. Mr. Arthur J. Altmeyer, chairman of the Federal Social Security Board, also has given the measure his blessing. Its provisions incorporate a considerable number of the activities included in what is known as the English Social Security Plan—a 100,000-word report—of which Sir William Beveridge, a recent lecture-visitor in the United States, is the special proponent.

So much in the way of information concerning the source material or inspiration personalities that have been identified with this "cradle to the grave" or "diaper to coffin" measure, as it has been called by some.

* * *

Medical and Hospitalization Care Are Among the New Features.—One of the reasons members of the medical profession should take special interest in the Wagner-Murray-Dingell bills is the inclusion of an elaborate set-up designed to provide in the not far distant future—through funds to be raised for the purpose—for federal insurance coverage for more than 100,000,000 of the population of the United States. It has been calculated that for hospital care alone, a sum between six and

seven million dollars would be required. For additional information concerning the financial phases of the plan, the reader is referred to the article "Regimentation of Medicine," which appears in this issue on page 112.

It is even provided in S. 1161 that the medical schools of the United States could be taken over and be maintained by the Government. Thus, medical graduates in days to come would be governmentally subsidized and indoctrinated from the first day of entrance into the freshman class of a medical school! This is somewhat similar to certain educational systems that have led to much havoc and sorrow in portions of Europe.

* * *

The Great Pooh-Bah for All the Medical Work Would Be the Surgeon-General of the United States Public Health Service.—In this new plan to place under governmental supervision medical education and practice, and medical and hospitalization care of more than one hundred million of fellow citizens, little less than totalitarian powers would be vested in one man—he, in turn, a governmental appointee, namely, the Surgeon-General of the United States Public Health Service.

As the chief administrator and dispenser of the vast sums of money involved in an annual collection of $3,000,000,000 or more each year, there would be placed on the shoulders of this one individual responsibilities almost as great and as incomprehensible to most Americans, as are the billions of dollars concerning which there has been much comment in the press in recent years.

It is true that the Wagner-Murray-Dingell bill provides for a "National Advisory Medical and Hospital Council," to consist of sixteen members, but these are to be appointed by whom? By the Surgeon-General of the United States Public Health Service, who, as before stated, will have all the powers of a totalitarian Pooh-Bah! Is it not possible to conjure conditions under which these appointees, or a majority of them, would be little more than "yes men"?

* * *

Brochure of the "National Physicians' Committee for the Extension of Medical Care" and Statement No. 11 by the "Committee for the Improvement of Medical Care, Inc."—The National Physicians' Committee performed a notable service when it sent to physicians its illuminating brochure, "Abolishing Private Medical Practice or $3,048,000,000.00 of Political Medicine Yearly in the United States," in which a factual analysis of the Wagner-Murray-Dingell bill is given. Every doctor of medicine who has not received the brochure should send his request for a copy to the National Physicians' Committee, Pittsfield Building, Chicago, Illinois.

In contrast, it is of side interest to note that the "Committee of Physicians for the Improvement of Medical Care, Inc.," an organization founded some seven years ago and of which Channing Frothingham, M. D., of Boston, is chairman and John P. Peters, M. D., of New Haven, Connecticut, is secretary, has come out of its retirement to issue Statement No. 11 (its last previous statement appeared in 1941). This organization promptly wrote Senator Wagner "The Committee of Physicians for the Improvement of Medical Care wishes to congratulate you on the presentation of S. 1161 . . . ," etc. Then follows some discussion on medical education and medical man power, the statement closing with some doubtful comment concerning the National Physicians' Committee and the source of the latter's funds and policies.

The National Physicians' Committee brochure and Statement Number 11 are of interest, since the first is realistic in its approach, and the other—far less so.

* * *

English Panel System of Physicians Is Included.—A panel system of physicians akin to that in operation in England is provided in S. 1161. The physician has the right to indicate whether he wishes to participate. However, knowing that the payments for services will come from federal funds which in good part will be under the supervision of lay bureaucrats, it is not difficult to imagine what kind of "political medicine" would soon come into being to take the place of medical practice as it has been so successfully conducted to date under a system of free enterprise.

* * *

California Medical Association Members Must Inform Themselves Concerning the Wagner-Murray-Dingell Bill.—It is to be hoped that members of the California Medical Association will take the time to inform themselves as fully as possible concerning the Wagner-Murray-Dingell bill.

But this self-education will not be enough! What is much needed is that every Doctor of Medicine in California shall perform his duty as a citizen, and as a member of the medical profession, by informing the two United States Senators from California and the Congressman from his district that he believes that the "Wagner-Murray-Dingell bill (S. 1161, H. R. 2861)" contains provisions that will be detrimental to the best interests of the public health, and that its passage would work to the harm of their constituents.

Readers are requested to refer to page 85 of the July issue of CALIFORNIA AND WESTERN MEDICINE, on which appeared the names and addresses of the United States Senators and Congressmen from California. Certainly, a letter to three of our national legislators is a service that is not too much to ask of every physician who loves his profession and wishes to do his bit in maintaining its standards in the promotion of the public health.

Many physicians fail to appreciate that earnest lawmakers wish to be kept in touch with the views of their constituents. In two recent union meetings of county medical societies held in northern California, two legislators, State Senator Herbert W. Slater of Santa Rosa and State Assemblyman Ernest C. Crowley of Fairfield, emphasized this fact, and pointed out that, if it was hoped they and their fellow legislators were to vote intelligently on medical matters—since their knowledge was

naturally limited concerning medical practice and public health matters—it would be necessary that their friends in the medical profession give them the essential informative data on these matters, to aid in their discussions and actions.

Wherefore, write your Federal Senators and your District Congressman. Why not do this now?

* * *

On How Members of the U. S. Congress May Be Kept Informed Concerning Public Health Legislation: California Public Health League.—No State in the Union has been confronted with adverse public health legislation more often than California. Only during the past several years has it begun to dawn on some of the eastern medical brethren how many and grave have been the public health problems (a term here used to comprehend licensure and other medical practice matters) that the medical profession of this State has been called upon to solve. That the solutions at times have been partial only and not entirely satisfactory should cause no wonderment. One need only look at kindred organizations in other commonwealths to be assured of this.

However, there is one accessory activity in which the medical profession of California may take pride, namely, the "California Public Health League."

This organization, composed of physicians, dentists, and nurses, is well organized in almost every county in the State. Its influence at Sacramento in protection of public health legislation cannot be gainsaid.

How has this been brought about? The answer is simple—by having key men and active workers in the legislative district of every State Senator and State Assemblyman who make it a point to keep these legislators in proper touch concerning the merits of proposed public health legislation. True it is, in order to maintain the efficiency of such a system, a strong central office and a representative are necessary.

In California there has been some hesitancy concerning extension of the work to include federal legislation. However, with impending social unrest and the many vagaries and theoretical expositions that are presented in the legislative chambers at Washington, D. C., and also in the absence of a coördinated effort under national auspices, California is not hesitant in presenting its plan to other constituent state medical associations as one worthy of most careful consideration.

It is all so evident. Members of the United States Congress will be glad to listen and act in proper manner when they know that a strong and influential group of constituent citizens is watching how their votes on public health matters are cast in the chambers of the Senate and House of Representatives.

In other words, to be heard in the legislative halls in Washington the opinion is spreading here, no matter what other States do or do not do, California henceforth must keep in better touch with its Federal Senators and Congressmen.

If, in every State in the Union there existed an actively working organization such as the California Public Health League—whether under such a name and as a separate entity, or a similar set-up as an expression of a Committee on Legislation and Public Policy of a constituent state medical association, would make little difference—then the deplorable and pathetic situations which have been coming to the front with increasing frequency at Washington, D. C., would probably not have arisen.

Let us keep in mind—

The message that will have most weight will be that which comes from the Senator's and Congressman's own constituents. There is no substitute for this.

EDITORIAL COMMENT†

POLIOCIDAL ACTION OF OZONE

Demonstration that certain strains of poliomyelitis virus are refractory to concentrations of chlorine used in routine water purification[1] has led Kassel[2] and his co-workers of the University of Southern California to study the possible poliocidal efficiency of ozone, which has long been known to be effective against certain other resistant microörganisms (*e. g.*, Endameba histolytica cysts). Two strains of poliomyelitis virus were diluted with saline solution and subjected to parallel sterilization tests with chlorine and ozone. In the chlorination tests, a tenth-volume of sodium hypochlorite solution or an equivalent amount of gaseous chlorine was added to the dilute virus, the final residual titer of the chlorine usually being about 0.5 p.p.m. In the ozonation tests, ozonized air was bubbled through the dilute virus mixture, the residual amounts of ozone usually being 0.05 p.p.m. At stated intervals measured samples of each mixture were treated with identical amounts of sodium thiosulphate and immediately injected intracerebrally into monkeys, the inoculation tests usually being made in triplicate. The resultant fatalities showed that the poliomyelitis virus is inactivated "almost immediately" (within two minutes) by ozone, while nearly three hours were usually required for similar inactivation with chlorine. Ozone, thus, is far superior to chlorine as a virucidal agent which "warrants additional experimentation."

W. H. MANWARING.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

PERTUSSIS ANTITOXIN

Isolation of a strain of Hemophilus pertussis capable of forming a high-titer specific toxin in artificial culture medium is currently reported by Roberts[1] of the Lederle Laboratories, Pearl River, New York.

Since the discovery of H. pertussis, preparation of a soluble whooping cough ectotoxin has been attempted by numerous investigators. Bordet,[2] Toomey,[3] Wood[4] and others succeeded in obtaining toxic filtrates from certain strains of the bacillus, capable of killing mice on intra-abdominal or intravenous injection, and of producing necrotic lesions on endermic injection into rabbits. These filtrates, however, were apparently nonantigenic, since they were not neutralized by an antibacterial immune serum, nor did they stimulate the production of antitoxin in laboratory animals. For this reason they were of little practical interest.

In the hope of improving such yields, the Lederle bacteriologists tested 61 different strains of H. pertussis on numerous types of culture media. The medium finally selected was a buffered beef heart infusion broth containing 2 per cent peptone and 0.1 per cent soluble starch. The broth was adjusted to pH 7.8 before autoclaving. The broth was inoculated with 24-hour seed cultures of the 61 strains, the resultant growths centrifuged and the supernatant fluids sterilized by passage through a Mandel filter.

Most of their 61 pertussis strains yielded practically nontoxic filtrates. Massive doses (0.5 c.c.) injected intravenously failed to kill mice. A few of the filtrates, however, were moderately toxic, killing mice in doses as small as 0.25 c.c. Culture No. 33, in contrast, yielded a highly toxic filtrate giving a 100 per cent mouse fatality on intravenous injection of doses as small as 0.021 c.c. death taking place within 24 hours. Injected endermically in 0.1 c.c. doses in rabbits, this filtrate caused local necrosis, the lesion reaching its maximum size in from 2 to 3 days, and subsequently sloughing to form a shallow ulcer.

The lethal and necrotic factors in this filtrate are thermolabile at all temperatures from 2° to 60°. At ordinary refrigerator temperatures (3 to 5° C.), the toxicity decreases about one-half within a month, and is completely lost by the end of 12 months. At ordinary room temperatures the toxicity is lost within 30 days, at 40° C. within 24 hours, and at 50° C. within 10 minutes. The lethal and dermal necrotic titers are lost simultaneously. Deterioration of the toxin can be prevented by the addition of 50 per cent glycerin, or 50 per cent sucrose, or by evaporating it to dryness. Dried filtrates suffer no demonstrable loss of toxicity for at least 18 months.

Toxin No. 33 is first demonstrable in broth cultures in about 2 days, increasing to a maximum titer in from 6 to 10 days. The toxin is highly antigenic. Rabbits are readily immunized by repeated subcutaneous injections of the filtrate, after which their skin is refractory to both the toxin and to live cultures of all strains of H. pertussis thus far tested. Rabbits thus immunized yield an antitoxic serum readily titrated by *in vitro* methods. Nontoxic toxoid prepared by the addition of formaldehyde, also stimulates the production of a specific antitoxin in rabbits.

While Roberts does not predict probable clinical application of the new toxoid and antitoxin, it is evident that the discoveries will stimulate new hope of improved methods in specific therapy and prophylaxis. Th situation is analogous to that in diphtheria and tetanus toxins a generation ago. The discovery thus represents one of the most encouraging contributions to basic immunological science of recent decades.

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Regimentation of Medicine*

Do you want the United States Government to take over and operate the practice of medicine? Do you want another bureaucrat, called a "Surgeon-General," to tell you whether or not you can be attended by the physician of your choice? Do you want to pay 6 per cent more of your wages into another governmental scheme for taking over another portion of your private life and create another gigantic bureau to regulate things here in this democracy of ours?

That's what Senators Robert F. Wagner (D., N. Y.) and James E. Murray (D., Mont.) propose in a bill introduced in the Senate to broaden the Social Security Act, and which will be called up for action when Congress reconvenes in September.

Under the guise of adding domestic and farm workers, sailors, employees of religious and charitable institutions, public servants and other smaller groups to the eligibles for old-age pension and unemployment insurance benefits, the bill would set up a detailed plan for bringing State Medicine to the United States, run from Washington by the United States Surgeon-General.

To finance the scheme, Social Security taxes on both employers and employees would be steeply increased. They would go to 6 per cent of wages up to $3,000 a year from each of these parties, as against the present 1 per cent from employees and 4 per cent from employers. Add that to your 20 per cent withholding tax and where are you?

One-fourth of the revenue raised would go to finance the Federal Government system—an estimated $3,000,000,000 a year. With this money the Surgeon-General would be required to arrange for general medical, special medical, laboratory, and hospital services for every one of the estimated 110,000,000 Americans covered by a broadened Social Security Act. He would be, as the New York *News* points out, the commissar of the United States medical profession, because of the powers this proposed law would give him.

These powers include: To enlist physicians for the services above described and hospitals likewise; to fix fees of

* For editorial comment, see page 109-110.

physicians rendering such services; to limit the number of patients to be cared for by each physician; to prorate patients among available physicians; to finance medical education and medical research.

Out of his $3,000,000,000 a year, the Surgeon-General is supposed to spend $60,000,000 for administration (more jobs for bureaucrats) and would pay out $2,400,000,000 in benefits. Under the "benefit" head he would be required to spend 2 per cent of the $2,400,000,000 or $48,000,000 on medical research and education. With this sum he could pretty thoroughly rip American medical education as follows:

Pay total cost of operating all sixty-six accredited United States medical colleges	$21,491,248
Subsidize 22,000 medical students at $700 a year for four years each	15,400,000
Spend for other research per year	11,108,752
	$48,000,000

Or if the medical schools and doctors objected to this, he could wreck them by spending his money this way:

Duplicate all existing medical teaching facilities in the U. S. A.	$22,000,000
Pay 20,000 additional medical students $700 a year apiece during their period of training	14,000,000
Spend in other ways as he pleased	12 000,000
	$48,000,000

The bill also empowers the Surgeon-General to muscle into the dental and nursing professions and "improve" them—something he would be well provided with taxpayers' money to do. What improvement any political control can bring to the medical, dental or nursing profession is another question, and we think, in view of the record made by most of our existing bureaus for regimentation, a most dubious one.

There are many weaknesses in our present system. Every individual should be entitled to all the benefits of modern medical science, if and when needed, regardless of his financial condition. Every child, for instance, who is stricken with infantile paralysis, should be able to command the very best of treatment, whether he be of poor or wealthy parents.

Adults, unfortunate enough to have sickness or other physical disorders in the family, should not find it necessary to work the rest of their lives to pay off doctor and hospital bills.

What the answer is to these and many other questions constantly arising, we wouldn't know. We have maintained for a long time, however, that they should come from the medical profession itself. And we hope the Wagner-Murray bill will scare the profession sufficiently to get these answers out without further delay.

Certainly political tinkerers and welfare workers are not qualified to do the job, and it looks to us as if the Senators had been sold a bale of extremely dangerous goods by some fanatic or other, who is one of the group taking advantage of the war to push their theories and fanaticisms onto the national statute books.

One thing all Americans should remember—that regimentation would never come to all groups of citizens at once. It would come group by group, profession by profession, industry by industry.

If the medical profession is established under a Washington commissar, it won't be long until the engineers will be under a dictator also. Then will follow the lawyers, the bankers, the public utilities, railroads, the airlines, and so on down the list.

The medical profession would be chosen first because it is the most vulnerable. If we allow it to be picked off, the rest will be taken over in due course. The time to make a stand is now. The whole principle of free enterprise is at stake. And there is no compromise!—Las Vegas (Nev.), *Review-Journal*, July 28, 1943.

The Rising Generation in Medicine

At no time is it more important to instill into the student mind those high principles which for so many years have guided the practice of medicine. There is, I fear, a growing tendency among students today to regard medicine purely from a materialistic standpoint. Even before the war many of the newly qualified, anxious to convert their acquired knowledge into terms of solid cash, rushed into contract or panel practice without holding any hospital house appointment whatsoever. Since the war the shortage of medical personnel has led to a greater demand for the newly qualified student, and the high fees now paid to temporary locums and assistants cannot but be harmful in the future when the period of present cheap money is past. Another present day aspect of medical student life which personally I much regret is the innovation of political student societies. It is a tradition of British medicine, as it is of the British Red Cross, that our service is independent of political creed. The doctor should be entirely impervious to political influences. His concern is with the great essentials of birth, life and death, which transcend all other considerations, and he should resolutely turn his back to the rival claims of political factions both at home and abroad.—Whitehouse, Sir Beckwith (president of the British Medical Association), The British Tradition of the New Outlook, *Brit. M. J.*, 2:357.

MEDICAL EPONYM

Scanzoni Maneuver

The description of this maneuver appears in "Die geburtshilflichen Operationen [Obstetric Operations]," which was issued by its author, Professor Friedrich Wilhelm von Lichtenfels, Scanzoni (1821-1891), of Würzburg, in the form of a reprint, with revisions, of a portion of the third volume of his *Lehrbuch der Geburtshilfe* [*Textbook of Obstetrics*] (1852). A portion of the translation follows:

"Our procedure under these circumstances is as follows: If the head lies with the brow anterior and turned to the left, so that the longitudinal suture runs in the right diagonal diameter, the left blade is applied in front of the left sacro-iliac synchondrosis, the right behind the right oval window [*eirunder Loche*]. . . . The head is then rotated, by turning the instrument from right to left through one-eighth of a circle, so that the longitudinal suture lies parallel with the transverse diameter of the pelvis.

"Both blades of the forceps are now removed and reapplied so that the left blade lies behind the left oval window, the right in front of the right sacro-iliac joint, whereby the occiput may be drawn under the pubic arch by again rotating the instrument."—R. W. B., in *New England Journal of Medicine*.

Lasting Values.—To have faith in the dignity and worth of the individual man, to believe that it is better to be governed by persuasion than coercion, to believe that fraternal good will is more worthy than a selfish and contentious spirit, to believe that in the long run all values are inseparable from the love of truth and the disinterested research of it, to believe that knowledge and the power it confers should be used to promote the welfare and happiness of all men . . . these are the values which are affirmed by the traditional ideology; they are the values which men have commonly employed to measure the advance of civilization; the values which men have celebrated in the saints and the sages.—From Carl Becker in *Yale Review*.

ORIGINAL ARTICLES

Scientific and General

RHEUMATIC FEVER: ITS INCIDENCE IN THE SOUTHWESTERN STATES*

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THE pronouncement has been made frequently that rheumatic fever is most severe and frequent in temperate and cold climates, that "wherever the weather is cold, wet, and changeable, rheumatic fever thrives." In other words, the disease has been said to flourish in those climates in which streptococcic infections commonly thrive. In my discussion, I shall attempt to offer an opinion based on definite clinical evidence that rheumatic fever occurs, with greater frequency than has been realized by reporters in the cardiac field, in tropical and subtropical climates.

Rheumatic fever, with heart disease, is far more frequent than any other cardiac ailment in childhood. It is almost the only form of chronic heart disease occurring in the age group under fourteen, with the exception of congenital heart disease. The etiology of rheumatic fever has been controversial. It is now fairly well conceded that a definite rôle is played in its causation by repeated infections of the beta hemolytic streptococcic group.

The seriousness of rheumatic fever makes it imperative for pediatricians, cardiologists, and educators to study and learn more about the occurrence, symptoms and prevention of the disease. Too little is now known about the incidence because, in most States, the disease is not reportable; and even in those States where it is supposedly done, reports are not made. In discussing this matter recently with the health officers of the southern counties of California, all of them confirmed the usual contention that rheumatic fever does not exist in Southern California.

The manifestations of rheumatic fever are systemic and may be associated with acute carditis, acute polyarthritis, chorea, myalgia, and insidious carditis. The disabling nature of the disease should demand from the medical profession an early diagnosis so that the appropriate treatment may be instituted and thereby morbidity and mortality reduced. The often-quoted figures of Jones,[1] from a ten-year study of 1,000 cases of rheumatic fever, indicate that only one-fourth escape the ravages of the disease, while another one-fourth die. This leaves one-half with residual cardiac damage; of these, one-sixth are totally incapacitated and one-sixth are for all practical purposes completely well, while two-thirds of the remainder are permanent cardiac cripples. There is no exact information which would permit evaluation of what early diagnosis and essential treatment would do in such cases.

Deaths from heart disease under forty years are almost entirely due to rheumatic heart disease. Therefore, we can assume that rheumatic fever contracted in childhood is reflected in the cardiac deaths up to forty years, which comprise 25 per cent of all cardiac deaths. These estimates are sufficient to prove that heart disease in childhood, which is largely rheumatic fever, constitutes an overwhelming public health program. Among school children only, heart disease is the fourth cause of death in the United States. Various estimates place the number of cardiacs in the United States at from 2,000,000 to 3,000,000, and about fifteen out of each 1,000 school children have some form of heart disease. In fifty years the incidence of tuberculosis has declined 50 per cent. The incidence of heart disease has increased 45 per cent. This contrasting picture is the result of better and more widespread dissemination of knowledge regarding tuberculosis, its diagnosis and treatment. Studies of the incidence of heart disease will serve notice to everyone concerned that we have a challenge to reduce the irreparable loss of hours due to the disease, especially in the months of emergency that face us.

AUTHOR'S SERIES

For the purpose implied in the title of this discussion, I have included a group of 112 proved cases of rheumatic fever studied in private practice, and have analyzed the information and reports on eighty-three additional cases admitted to one of the private hospitals in San Diego, California. These patients were all children, ranging in age from three to fifteen years. They were all natives of Southern California or southwestern Arizona, and had not resided outside that area at any time. The purpose of the study was to determine the type, severity and season of onset, and the extent of cardiac damage in these patients. In all of these cases careful histories were taken, with special reference to hereditary, economic and environmental factors and infections, their nature and extent. Examination included thorough physical inspection, together with electrocardiographic studies, fluoroscopic and x-ray examinations of heart and lungs, blood counts and sedimentation rates. The diagnosis was based on the composite picture of these findings.

In this series of 112 cases in private practice, 70 were females and 42 males, showing the usual predominance of females reported by other observers. The onset of the disease in 55 instances was in the spring; summer in 22; fall and winter in 45. The youngest patient was two and one-half years old and the oldest, fifteen years old. The largest number of cases occurred in the age group between six and twelve years. The symptoms varied from those starting with acute polyarthritis, with acute carditis and high fever from the beginning, to the mild, insidious case initiated by joint pains and low-grade fever, with cardiac manifestations and findings later. The course of some was short, with normal heart findings after the attack. In most instances there was evidence of permanent

* Presented at the annual meeting of the California Heart Association, Los Angeles, May 1, 1943.

valvular heart disease. The average case showed the signs and symptoms for weeks and months. The fever persisted, the appetite remained poor and the color pale, pain in muscles and joints remained, and evidence of cardiac failure occurred at intervals. After variable periods symptoms improved, and appetite, color and weight were regained. The heart findings remained, however, and recurrent, acute exacerbations were evidenced in most cases, with further heart damage resulting. In this series of cases, chorea and rheumatic nodules were rare. Occasional erythemas and abdominal types of onset were found.

REPORT OF CASES

CASE 1.—The patient was a female, born on January 12, 1939, a native of Southern California and had always resided in that area. She was the daughter of a physician. There was no family history of rheumatism. The past history revealed many attacks of otitis media and tonsillitis. Examination in January, 1940, showed a pale, underweight female of one year. There was a history of nervousness, irritability, lack of appetite and repeated respiratory infections. There were no joint or muscle pains. Physical examination was negative except for hypertrophied and infected tonsils, underweight, and obvious anemia. The heart was normal. Blood count showed 3½ million red blood cells and a hemoglobin of 72 per cent. Blood sedimentation rate was normal. During the spring of 1942, recurrent colds, sore throats, and otitis media occurred. She was fairly well during the summer of 1942. She had a tonsillectomy and adenoidectomy in August, 1942, from which a good postoperative recovery was made. Her respiratory infections began again in October, in spite of an ideal dietetic management with high vitamin intake, sun baths, and respiratory vaccines. Up to January, 1943, there were no indications of rheumatic fever. At that time there was a sudden onset of severe muscle and joint pains, associated with temperature ranging up to 104 degrees Fahrenheit, with almost immediate cardiac involvement, consisting of tachycardia, cardiac enlargement and a valvular lesion, mitral in type. The first acute attack persisted about two months. The diagnosis was amply proved by the symptoms, course, and obvious carditis. Laboratory findings showed the usual secondary anemia and a markedly increased sedimentation rate, up to 100. Here we have a typical case of acute rheumatic fever developing in a subtropical climate, where economic and housing conditions were ideal, with the consequent development of a chronic, disabling heart disease.

* * *

CASE 2.—The patient was a male, ten years of age, born in the Imperial Valley, California, where he had always lived. There was no hereditary factor of rheumatic fever. The patient was first seen in May, 1940. The only pertinent point in the past history was the occurrence of repeated colds and respiratory infections for several years prior to the examination. A tonsillectomy and an adenoidectomy had been done at two years of age. In March, 1940, he had a sudden onset of severe muscle and joint pains, with temperature ranging from 100 to 103 degrees Fahrenheit, loss of weight, sweating, nosebleeds, and lack of appetite were associated. Shortness of breath, pounding of the heart, and a slight edema of the ankles developed shortly. No record of any heart findings or electrocardiographic tracings were made by the attending physician at the time. Physical examination in May, 1940, showed a pale, underweight, male child of ten years. The positive physical findings were largely cardiac, consisting of definite evidence of cardiac enlargement by fluoroscopic and physical examination and a definite harsh systolic murmur with signs of partial heart-block. The electrocardiogram showed a ventricular rate of 65 to 70, irregular. The P-R interval varied from 0.16 seconds to almost simultaneous occurrence with the QRS wave, and at times there was no P wave preceding the QRS complex. The blood picture showed secondary anemia, and the sedimentation rate was 36. Observations at regular intervals have shown a complete clearing of the heart-block. The cardiac enlargement has persisted, and a permanent mitral heart lesion has developed.

* * *

CASE 3.—The patient was a female, seven years of age. She had been born in the Imperial Valley and had lived there for the seven years of her life. The family history and environmental history were negative. The past history was negative, except for severe measles at two years of age and mild scarlet fever at three years. A tonsillectomy had been performed at three and one-half years because of repeated attacks of tonsillitis, occurring after the scarlet fever. She was first seen in March, 1941. About one month previously she had had a slow, insidious onset of recurrent muscle and joint pains, with fever ranging from 99 to 101 degrees Fahrenheit. She complained of fatigue, did not eat well, slept poorly, and lost some weight. Examination showed a pale, somewhat underweight female child of seven years. The positive findings were mainly cardiac. The heart was slightly enlarged, with definite evidence of a mitral *lesion*; tachycardia and a slight elevation of blood pressure were associated. Electrocardiograms confirmed the physical findings. Low-grade fever was present, as were definite secondary anemia and an increased sedimentation rate.

* * *

CASE 4.—The patient was a male, fourteen years old. Born in Yuma, Arizona, he had lived there for four years and in San Diego for the remainder of his fourteen years. The family hereditary story showed a history of rheumatic fever. The father had a rheumatic heart disease, and a brother, four years younger than the patient, had a similar condition. He had had measles, pertussis and scarlet fever, and at the age of eight a tonsillectomy had been performed. He had had psoriasis for ten years. In the spring of 1941, he fell and sustained an injury to his right knee joint, for which the attending physician applied a cast for several weeks. After the removal of the cast, it was noticed that not only was the right knee swollen and tender, but that the left knee and the smaller joints of the fingers and toes began to enlarge and become very tender. Low-grade fever and general malaise were associated. I first saw him in October, 1941, at which time he was completely bedridden, with severe, generalized polyarthritis. His heart was enlarged, with a rapid rate. Associated was the finding of a mitral lesion. These observations were confirmed by his electrocardiogram. The sedimentation rate was increased, and there was marked albuminuria and secondary anemia. Since that time he has run a low temperature, and there have been periods of regression and exacerbation of the joint condition. His heart is permanently damaged.

COMMENT

Similar case histories could be repeated for all the others studied. The rheumatic fever ranged from mild to severe, as has been observed in other climates. Complete analysis of these cases, together with a summation of the findings in the additional eighty-three records checked at a private hospital in Southern California, enables me to offer several comments regarding the incidence and other characteristics of rheumatic fever in the southwestern United States as follows:

1. Acute rheumatic fever and rheumatic carditis are found far more frequently in this area than has been claimed by most observers. The incidence can be charted more accurately if the law requiring reportability of the disease is systematically observed by all of us.

2. The severity of the cardiac complications is approximately as great as in colder and more severe climates.

3. Poor housing and economic conditions do not seem to be contributory factors to the disease in this area.

4. Repeated respiratory and throat infections of a streptococcic type seem to precede the actual onset of the acute attack.

5. The removal of tonsils and adenoids does not seem to alter the incidence of the disease nor does removal act as a prophylaxis.

I trust that stimulation to further studies, especially in children who, after all, are the cardiac problems of later years, may be induced by this and other efforts of a similar nature.

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THE DISPOSITION OF SUBSTANDARD MILITARY PERSONNEL*

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HOW to eliminate physically and mentally handicapped soldiers and thereby procure and maintain a dynamic army has been a serious military problem since earliest times.

The disposition of such substandard military personnel was a matter of concern at least as far back as the time of David. Some years after his epic struggle with Goliath, David's home town was burned (I Samuel, Chapter 30), and his two wives, with others, were taken captive and considerable property carried away. "But David pursued, he and four hundred men; for two hundred stayed behind, who were so faint that they could not go over the brook Besor." In other words, about one-third of his six hundred men "were so faint"—or, in our language, so physically or mentally disabled—that they had to be eliminated from the army as unfit.

Exactly how David determined who were so faint and, therefore, incapacitated for his army is not told, but nowadays the job is handled by the doctors. In this era, before men joined the Army, both civilian and Army doctors tried to keep the unfit from becoming soldiers. Many of them were kept out. As proof of that fact, Colonel Leonard G. Rowntree's statistics are presented as given in *The Military Surgeon* of March, 1942.

TABLE 1.—*Selective Service Induction Rejections*

Cause of Rejection	No.	Percentage
Dental defects	188,000	20.9%
Defective eyes	123,000	13.7%
Cardiovascular	96,000	10.6%
Musculo-skeletal	61,000	6.8%
Venereal	57,000	6.3%
Mental and nervous	57,000	6.3%
Hernia	56,000	6.2%
Defects of ears	41,000	4.6%
Defects of feet	36,000	4.0%
Defective lungs	26,000	2.9%
Miscellaneous	159,000	17.7%
	900,000	100.0%
Illiterates	100,000	
Rejected	1,000,000	(50%)
Accepted	1,000,000	(50%)
	2,000,000	(100%)

SELECTIVE SERVICE REJECTIONS

It will be noted that the figures given in Table 1 were compiled at about the beginning of our entrance into this war. Since then standards have been lowered in order to allow men with minor physical defects to function in limited service capacities.

At about the same time, in March, 1942, we studied our series of cases in order to determine what types of diseases were most difficult to detect on the induction examinations. We found that we had 582 cases and of these, 502 were soldiers discharged on a Certificate of Disability, and 36 by "Section VIII" Board procedure. Sixteen were retired for disability after twenty years of enlisted service and twenty-eight officers were retired for various incapacities.

It should be stated that the enclosed facts and opinions are not official. They are my own and they do not necessarily reflect the opinion of the Surgeon General or the War Department.

ON SOLDIERS DISCHARGED FOR DISABILITY

The following chart is an analysis of the causes and the line of duty status of the 502 soldiers who were discharged on Certificate of Disability.

TABLE 2.—*Soldiers Discharged on Certificates of Disability*

	No. of Cases	% of Total C. D. D.'s	Line of Duty YES
Nonorganic diseases of central nervous system	251	50.0%	10 (4.0%)
Orthopedic	81	16.1%	12 (14.8%)
General medical	59	11.8%	3 (5.1%)
Eye, ear, nose and throat	38	7.5%	5 (13.2%)
Organic central nervous system	22	4.4%	1 (4.5%)
Cardio-vascular-renal	20	4.0%	6 (30.0%)
Gastro-intestinal	13	2.6%	1 (7.7%)
Tuberculosis, pulmonary	10	2.0%	4 (40.0%)
Miscellaneous	8	1.6%	0 (0.0%)
TOTALS	502	100.0%	42 (8.3%)

COMMENT

These charts reveal that 50 per cent of the first two million men examined were rejected: 45 per cent for physical or nervous difficulties and 5 per cent for illiteracy. One would expect that those who were selected for the Army would be fine

* Read before the second general meeting at the seventy-second annual session of the California Medical Association, Los Angeles, May 2-3, 1943.

The opinions and assertions contained herein are the private ones of the writer and are not to be used as official or reflecting the view of the War Department or the war service at large.

physical specimens—and so they were, in general. It is, nevertheless, true that the care and disposition of the unfit in the Army remains a substantial portion of the work of the named general hospitals. To emphasize this point it was conservatively estimated at the time these charts were made (March, 1942) that, of the cases entering our general hospital, at least one out of every three would be discharged from the military service because of physical or mental disability.

It was noted in Colonel Rowntree's figures that only 6.3 per cent of those rejected were kept out of the Army because of nervous and mental diseases. Of those we discharged from the Army for disability, 50 per cent were mental and nervous cases exclusive of the organic central nervous system diseases. One hundred sixty-two men, or approximately one-third of all of these 502 cases, were discharged because of psychoneurosis, and sixty-one were discharged because of psychoses. More recent figures suggest an even higher percentage of mental and nervous diseases. In addition, many cases with organic disease have a surprising amount of accompanying psychoneurotic overlay. The mental and nervous cases are, therefore, the hardest to detect on induction examinations, and they are by far the greatest disability problem in the Army. The same situation is apparently present in every army in every war. Every effort must be made to keep mental and nervous disabilities from undermining the morale of the troops, and from becoming a staggering future pension problem.

THE MEDICAL OFFICER AND THE SUBSTANDARD SOLDIER

Now that we have been introduced to the problem of the substandard soldier statistically, let us join the Army as doctors and get the atmosphere surrounding this matter of disposition.

When a medical officer enters the military service he is usually assigned to duty with one of two large groups. Either he is assigned to duty in the field with troops, in which case his life is largely that of his brother officers in the combat outfits, or he is assigned to one of the fixed hospitals, in which case his life is rather like that of a resident in a civilian hospital.

If one is assigned to duty with troops, the atmosphere is likely to be that of any combat unit in training for action where morale is high and the men are healthy in body and mind. When an illness develops which is sufficiently severe to keep the soldier from doing full duty, he is usually put in a hospital. There is no such thing as light duty in the Army. A soldier either works full time or he is hospitalized.

Let us imagine that a soldier complains of pains in his abdomen so severely or so persistently that his medical officer feels that the soldier cannot do his daily duties efficiently, or that the symptoms call for further investigation. The soldier is probably seen in a dispensary and is then sent to a station hospital or its equivalent.

The doctor in a station hospital who sees this soldier is accustomed to seeing many minor illnesses and occasional grave emergencies. The turnover of patients is considerable, with the great majority soon returning to duty. A certain number require more prolonged study or convalescence. Many of this latter group are transferred to a general hospital for further treatment or disposition. The station hospital functions actively in discharging disabled soldiers from the service. Our hypothetical patient was found to have a story suggesting peptic ulcer, but his x-ray was negative and he was refractory to treatment. He was placed before a board of officers in the station hospital with a view to discharging him from the Army because of his physical disability, but because of the negative x-rays and his unsatisfactory clinical condition he was sent to a general hospital for further investigation, treatment, and disposition.

The doctor in a named or domestic general hospital who will care for this patient is accustomed to seeing a few acute and many chronic illnesses, and an occasional unusual and complicated case. Many of his patients can be returned to duty within a reasonable length of time with an expectation that they will perform satisfactory service. A considerable number, apparently about one-third, cannot be salvaged and must be discharged from the Army. The doctor in a general hospital, coming from civil life, is impressed by the fact that one of his important duties is to estimate as quickly as possible whether or not a particular soldier will be of value to the war effort in the Army or whether he will be more trouble than he is worth. The doctor cannot, as in civil life, continually bolster his patient mentally and physically to permit the soldier to do a part-time job. Many of those discharged from the Army because they cannot adapt themselves to Army life can function very satisfactorily as individuals in civil life and do much to forward the war effort.

ON RETURNING DISABLED SOLDIERS TO CIVIL LIFE

In addition to being an industrious and capable physician, the general hospital doctor in particular must become expert in the matter of disposing of his patients as promptly and as correctly as possible. Let us confront with him the technique involved in discharging a soldier to civil life for a disability. There are several ways to accomplish this, depending upon the disability and the length of service of the soldier.

The soldier with an incapacitating disability must be recommended for discharge by the ward officer. With the approval of the chief or executive of the service, the soldier will then come before some board of officers appointed by the commanding officer of the hospital. This board usually consists of approximately two senior officers and one junior officer. By far the busiest board of officers is the Disability Board, commonly called the C. D. D. Board, which recommends a Certificate of Disability for Discharge in appropriate cases. It is noteworthy that no board of officers does more than recommend. Only when the commanding

officer or other specified higher authority approves the findings of a board of officers is the recommendation acted upon.

Our hypothetical patient with the bizarre abdominal symptoms, after careful investigation, was found to be suffering from incapacitating nervous indigestion or, in our terminology, psychoneurosis, chronic, severe, and was "C. D. D.'d" on that basis.

A less common and less desirable exit from the service for the enlisted man is by recommendation of the "Section VIII" Board of Officers, which deals with the chronic alcoholics, the constitutional psychopathic states, the mental deficiency cases and the inapt.

Use is also made of "Section X," which enables certain commanding officers to discharge "for the convenience of the Government" recently inducted limited service soldiers who are obviously unfit for military service. Enlisted men with twenty years or more of military service may be ordered before a special board of officers for consideration of retirement rather than discharge when they have a disability.

DISPOSITION BOARDS OF THE MEDICAL SERVICE

Before an officer is retired he must be examined in a general hospital by a special board of officers called a Disposition Board, which is an advisory board to the commanding officer. This board can recommend that the officer return to full duty, that he be reclassified for limited service, or that he be ordered before a Retiring Board. A Retiring Board consists of two or more medical officers, three or more nonmedical officers, two medical witnesses, and a recorder.

Most soldiers discharged for physical or mental disabilities are given a white, or honorable discharge. If the condition is due to a venereal disease, to chronic alcoholism, or to certain constitutional psychopathic states, a blue discharge or discharge without honor, is usually given. No discharge for disability of any type is ever used as a disciplinary measure. A yellow, or dishonorable discharge is given only after the action of a general court-martial, and it is not given for physical or mental disability.

When a soldier or an officer with an incapacity appears before any of these boards, many general rules, regulations, and factors must be taken into consideration.

The patient must have a disqualifying disability. Excellent guides for determining whether or not a given condition is really incapacitating is gained from such directions as Mobilization Regulations 1-9, and Army Regulations 40-100, 40-105 and 40-110. These and other regulations, circulars, and directives are written in the light of much medical military experience, and one gains a wholesome respect for them. They are used somewhat more strictly on admitting enlisted men and officers into the Army than they are in discharging or retiring men from the service. Clinical judgment is used hand in hand with the regulations.

The ward officer must have the case well worked up clinically. All necessary facts on which to base a decision must be present to enable the Board to reach a fair decision. This is particularly true in the case of the psychoneurotics. A psychiatrist passes on each case diagnosed as psychoneurosis after organic difficulties have been carefully ruled out or evaluated by adequate consultation. Positive evidence of a psychoneurosis is required, as psychoneurosis is not diagnosed merely by exclusion of organic difficulties in an ailing soldier. We find very little malingering, a condition dealt with by courts-martial. We are quite aware that a certain piece of white paper, an honorable discharge, will cure many a backache or limp. We know that when these ex-soldiers arrive home and handle a good job satisfactorily, it may be felt that insufficient consideration was given to his case. Our early reactions were to send such psychoneurotics back to duty or to reclassify them and make them work. We did send them. They did not do much work. And they came back to the hospital. They were called "shell shock" cases in the last war. A variety of names are used in this war. Our term for some of them is "broken blossoms." We are sure that in general these psychoneurotics will do more for the war effort in civil life.

All the necessary evidence must be available to the Board in order for it to settle the line-of-duty status of the patient. A soldier or an officer discharged with a disability incurred in line of duty is entitled to certain pension rights or retirement benefits under the present law. In other words, in cases disabled in line of duty the Government assumes responsibility for the disability. In general, disabilities are said to be in line of duty if they are the result of injuries incurred while on duty or on authorized leave, or when the disability follows an acute illness at any time after induction, or when a chronic mental or physical disease first appears after six months of active service. Disabilities are not in line of duty when they occur as the result of the patient being drunk, absent without leave, or when they are the result of venereal disease. Chronic diseases such as coronary sclerosis, carcinoma, hernia, tuberculosis, or duodenal ulcer, are usually considered to be not in line of duty when the first symptoms appear within the initial six months of active service. At times the line-of-duty status becomes fairly complicated, as does the matter of whether there has been permanent aggravation of a condition considered not in line of duty. Permanent aggravation also carries with it certain financial responsibilities on the part of the Government.

ON TYPES OF MILITARY SERVICE

If possible, officers and enlisted men are placed on limited service rather than retired or discharged. General military service means that he can do any type of duty anywhere he may be sent. Limited military duty means that the enlisted man is physically fit for certain types of active military assignments commensurate with his physical qualifications. It does not mean that he is only fit for part-time or light work. Limited service does mean that he is fit for full duty only under certain cli-

matic or other conditions. Limited service does not necessarily disqualify a man for overseas duty.

There are many other special problems involved in disposing of the substandard military personnel, but enough has probably been said to give a general idea of the work involved in disposing of them. To the layman the term "disabled military personnel" brings to mind those men who have been wounded in battle. Theirs is a special problem and, fortunately, a relatively small one to date. It is, however, governed by the same basic principles.

It has fallen to the lot of some doctors to go out to adventurous fields with long periods of waiting, alternating with sudden excitement and the opportunity to be of incalculable value in saving life and limb at the forefront of battle. The lot of some of us has been to work prosaically in an effort to take care largely of prebattle illnesses and injuries. We feel that it is a very important by-product of this plodding work to help maintain a dynamic army by carefully sifting out the military unfit; or, in the language of David's time, to leave behind those that "were so faint."

Hoff General Hospital.

WOMEN IN INDUSTRY *

A STUDY OF ONE HUNDRED AND THIRTY-FIVE WOMEN WORKING AS RIVETERS IN THE AIRCRAFT INDUSTRIES

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AND
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ACCORDING to a recent survey published in the February number of *Fortune* magazine, about twelve and one-half million women were in the war-working force by December of 1942. About three and one-half million more will be needed in 1943, giving a total of about sixteen million women in essential work by the end of this year. A great many of these women are being employed in the aircraft industry. Sixty per cent of the employees in some plants are women already.

With the institution of numerous aircraft plants in California, thousands of women throughout this State are replacing men at this work. It has been said that women are not physically equipped or emotionally stable enough to do all the kinds of work that men can do. This has, naturally, resulted in numerous problems. The solution, for the most part, has been in the hands of the industrial group of physicians whose training and past experience had been chiefly the prevention and treatment of industrial accidents and occupational diseases. There can be little criticism and much praise of the manner in which they have responded to a tremendous task.

On the whole, little interest has been shown in the problem by those in the medical profession not directly connected with this type of work. This is easy to understand, with the ever-increasing volume of private practice. It is for this reason that this paper is being presented in the Section on Gynecology and Obstetrics, rather than in the Section on Industrial Medicine. It is felt that those who, in the past, have been leaders in the field of gynecology and obstetrics should take an active interest in the protection of the health of women who are doing a big part of the winning of this war.

RECOMMENDATIONS OF COUNCIL ON INDUSTRIAL HEALTH

The Committee on the Health of Women in Industry of the Section on Gynecology and Obstetrics, headed by H. Close Hesseltine, made certain preliminary recommendations to the Council on Industrial Health before the Fifth Annual Congress in Chicago in January of this year. The following general statement was made:

> Shortage of manpower and economic pressure necessitate the employment of millions of women in industry. Sufficient medical data are not available to draft final recommendations about the effect of various kinds of employment on the gynecologic or future obstetric health of women. . . . It is common experience in industry that women absent themselves from work more often than men, and that the duration of the individual absences tends regularly to be longer. The available data do not clearly assign the responsibility for this tendency directly to obstetric or gynecologic function (though it has been taken for granted by some) as against ordinary causes of disability which are equally applicable to men. All of these relationships need careful study over an extended period of time.

A review of the literature on the subject confirms the above report. Most articles deal with the subject of women in industry in a general way and few detailed reports are available. There are several surveys on postal clerks made by the United States Public Health Service. Their results indicate that women are absent much more often than men, but that the great majority of the absences are due to upper respiratory infections and other illnesses common to both sexes. Reports from all large centers reveal that a 5 to 15 per cent of workers engaged in war work are daily being reported absent. The normal peacetime estimate is 2 per cent. It has been determined that 35 to 50 per cent of this so-called "absenteeism" is due to physical disabilities.

With the many new types of work being done by women, numerous unusual complaints are being heard. There have been rumors among the women workers that riveting causes "female trouble." Some of the local physicians speak of the condition as "riveters' ovaries." This has stimulated a study of this particular problem to prove it either as a fact or a fictitious rumor, unfounded on true experience and possibly arising as a form of propaganda.

SOURCE OF MATERIAL

One hundred and thirty-five women riveters with pelvic complaints were studied. Some were admitted to the Santa Monica Hospital by private physicians for treatment, and others were examined and studied by one of the authors in a medical

* Read before the Section on Obstetrics and Gynecology at the seventy-second annual session of the California Medical Association, Los Angeles, May 2-3, 1943.

group treating plant employees. These were chosen because of the complete work-up of the patients and accurate pathological diagnosis of the operated cases in the hospital. Patients who were pregnant and developed complications were eliminated because of the probable inaccuracy of the history in these cases.

RECORDED DATA

The following items on each patient were recorded: age, previous occupation, pregnancies, operations, previous pelvic diagnosis, chief complaints, clinical findings on examination or pathological findings at operation.

Due to the prevalence of menstrual complaints, the following record was kept of these cases:

Menstrual history before employment as a riveter, including interval, duration, regularity, clots and dysmenorrhea, menstrual history since employment as a riveter, including interval, duration, regularity, clots and dysmenorrhea.

RESULTS

Tables 1, 2, 3, and 4 give information concerning the results.

TABLE 1.—*According to Age*
Ages 18-48 Years

Under 20	8	6%
20-29	73	54%
30-39	38	28%
Over 40	16	12%

TABLE 2.—*According to Occupation*

Occupation—riveters	135		100%
Previous occupation—			
40 ..... 30% Light work, such as clerks and waitresses			
95 ..... 70% Listed as housewives			
III—According to Personal History (Illness)			
Previous pelvic operations	30		22%
Pregnancies	84	62%	1-9 each
Previous pelvic complaints	11	8%	

TABLE 3.—*Menstrual History After Employment as a Riveter in Relation to the Previous Menstrual History*

Dysmenorrhea before riveting	81	60 %
Increase in clots with menstruation	33	24 %
Increase in dysmenorrhea	46	34 %
Development of interval irregularity	39	36 %
Increase in the duration	75	56 %
Decrease in the duration	3	2.2%
Menorrhagia	54	40 %
Aggravation of menstrual complaints	114	84 %
No change in menstruation	21	15 %

TABLE 4.—*According to Authors' Diagnoses*

(Clinical and pathological diagnosis of the 135 patients)		
Chronic pelvic inflammatory disease	52	38 %
Fibromyomata uteri	33	24 %
Fibros uteri and dysfunctional bleeding	13	9 %
Endometrial hyperplasia	14	10 %
Prolapse, rectocele, cystocele	9	6.5%
Cervical or endometrial polyps	5	3.7%
Endometriosis internal and external	4	3 %
Idiopathic uterine bleeding	4	3 %
Hyperthyroidism	1	7 %

Of the 135 women riveters studied, a pathological pelvic condition was diagnosed in all but five cases. Of the 54 cases of menorrhagia, 50 were examined and a pathological condition discovered in 49. No cause for the bleeding could be determined in two cases seen in the office, and two cases completely worked up in the hospital. The other case was one of hyperthyroidism.

COMMENT AND CONCLUSIONS

This report is preliminary, for it has been difficult to establish controls in the eight months of the investigation. Only probable conclusions can be arrived at at this time. This evidence, based on the study of 135 riveters with pelvic complaints, is offered in support of our contention that pathological pelvic conditions are probably subject to aggravation in riveters. With the exception of five cases, there was definite evidence of previous pelvic pathology before employment as a riveter. The presence of four cases where no cause for the pathological uterine bleeding could be determined is too small a group to suggest probabilities, though the smallness itself infers that riveting probably causes no pathological condition in the pelvis, or at least not frequently. We have no evidence as to the mechanism by which pathological conditions in the pelvis are upset by riveting. There are two outstanding theoretical possibilities. The mechanical vibration directly disturbs the physiology of the ovary, which is already unbalanced by existing disease; or, indirectly, the patient becomes emotionally upset by the constant vibration and noise, and this affects the physiology of menstruation.

We further believe that a good number of manpower hours can be conserved by a careful history and, more important, by an adequate preplacement examination of the pelvis of women workers. Some plants have good preplacement examination routines, including a careful pelvic examination. This should become universal. The number of manpower hours lost in transferring one riveter to another type of work after losing several weeks due to illness is costly. Paul McNutt, Chairman of the War Manpower Commission, says, in speaking of manpower conservation:

> Industry has a bigger task than saving that time lost to prevent diseases and accidents. Your assignment is total conservation of manpower. Like military medicine, it means prevention and restoration. Prevention has the high objective of throwing around the soldier every known health protection to keep him in action. If he does succumb to sickness, accident or enemy attack, the duty is to restore him to action as quickly as science, skill and nature permit. Your task is to do the same for the men and women in our war industries. . . . Our industrial army without whom the United Nations cannot win."

It has been worked out that the next large group of women to be taken into the war industries will be drawn from married women with children over sixteen years of age. This means that fewer cases of pelvic inflammatory disease and abortions will be seen, and more cases of pelvic relaxations, dysfunctional uterine bleeding, carcinoma of the cervix, and the menopausal syndrome. These pathological conditions should be corrected before employment. Many of these patients are now under the care of their family doctor. An effort should be made to have these patients have an adequate preplacement examination. This should be our problem and responsibility to see that this is done. Industrial plants have a list of specialists who are consulted when needed. Doctor Hesseltine has recommended that a gynecologist and obstetrician

should be added to this list where a substantial number of women are employed. We think that this is a step in the right direction. For example, very few plants require routine interval check-ups, and yet here is an unparalleled opportunity to reduce the mortality rate of carcinoma. Industrial physicians are doing an excellent work in protecting the health and welfare of the nation's large number of industrial employees. They need the experienced and trained specialist to control and study the problems of women workers, that adequate rules and regulations can be drawn up for their protection and well-being.

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CANCER OF THE UTERUS: THE VAGINAL SMEAR IN ITS DIAGNOSIS*

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AND
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A NEW method for detecting the presence of uterine cancer is based upon the well-established vaginal smear technique. Much use has been made of vaginal smears in the study of the reproductive cycle in laboratory animals, as well as in women. Cells from the various epithelial surfaces of the uterine canal, the cervix and the vagina undergo changes in morphology and staining properties which are sufficiently characteristic to enable one to evaluate much of the normal or abnormal hormonal physiology responsible for the variable cell patterns. It is only necessary to collect the exfoliated cells from the posterior vaginal fornix; spread them upon a clean glass slide, fix them in an alcohol and ether solution, stain them, and they are ready for study under the microscope.[2]

In the course of routine studies of human vaginal smears, Papanicolaou discovered that not only were the normal cells shed and hence demonstrable in the vaginal smears, but also many pathological cells could be found, among them those of cancer.

AUTHORS' STUDIES

To determine the relationship of cancer cells in the vaginal smear to the incidence of malignant disease in the uterus, as demonstrable by clinical methods and the biopsy technique, Papanicolaou and Traut have collaborated in a study covering three years at the Cornell Medical College. Vaginal smears, many thousands, were made and studied, with the result that, in their hands, the method has been demonstrated to have a decided advantage in that it enabled them to detect cancer without even a minor surgical procedure. The preparation of vaginal smears is easy, may be quickly carried out, and can be repeated at frequent intervals whenever desirable.

It is particularly valuable in the diagnosis of very early carcinoma of the cervix and fundus—even before such lesions can be demonstrated by the biopsy method—with the single exception of adenoma malignum.

METHOD USED

The method, therefore, will be described in some detail in the hope that others may become interested in learning how the malignant cells can be recognized. An adequate description cannot be attempted, however, for lack of space. The interested reader is, therefore, referred to a more complete work which is to be available shortly.[3]

The malignant epithelial cells exfoliate from the surface of neoplastic growths, much as do normal cells. They then float downward into the vaginal fornix, where they accumulate and become mixed with normal cells of epithelial and blood origin, as well as with mucus, bacteria, parasites and cellular débris. The rate of exfoliation of the malignant cells seems to be dependent upon the rate of growth of the neoplasm and its size. Young, small, and slow-growing lesions, therefore, usually shed only few cells, whereas a large and rapidly growing lesion will ordinarily contribute relatively rich showers of characteristic cellular elements.

Meticulous scrutiny of the stained smear preparations is an important essential as well, as that such searching may be done by a person trained in the details of this type of cellular diagnosis. An atlas[3] with colored illustrations has been prepared and will shortly be available to aid those interested in learning the method. The details of the staining technique will also be given in all the details necessary to duplicate the color reactions as shown.

DIFFERENTIATION

In brief, the differentiation of the malignant cell from those of benign origins is based upon changes in the size, shape, staining reactions, and the characteristics of the chromatin elements in the nucleus, the nucleoli, and the cytoplasm. Variations in size, with lobulated, crenated, or elongated nuclei are most suggestive. If, in addition, the chromatin shows fragmentation, granulation, or displacement to one or other pole of the nucleus with one or more nucleoli, the probabilities of malignancy are great. If, in addition, one sees numbers of such cells in close proximity to one another so that the above criteria can be established by accurate comparison, a presumptive diagnosis of malignancy can be made. The word "presumptive" is used advisedly, as we do not feel one should ever use this method as the basis for an absolute diagnosis. Each of the

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different types of carcinoma, such as those of squamous or glandular origin, shows a great variety of changes, such that the microscopist must be well acquainted with the many cell forms. Description of the many variations is not only difficult but practically impossible; therefore, resort must be made to illustrations, or to the study of the smears themselves, if one is to become proficient or reliable in their evaluation.

The vaginal smear presumptive diagnosis should be substantiated by use of the biopsy. It might be inquired, then, what is the particular value of the vaginal smear in the diagnosis of cancer of the uterus? The answer is that the vaginal smear can be applied to larger numbers of women because of its simplicity and ease of application, whereas the biopsy can only be used when one has at hand all the facilities for a minor surgical procedure. Furthermore, the vaginal smear can be made to reveal the presence of cancer when it cannot be demonstrated by any other means. In addition, the vaginal smear may be made without trauma of the parts, and thus the dangers of dissemination by way of open lymphatics are avoided. For these and other reasons it is of distinct value in addition to the possibilities offered by the other methods of diagnosis available to us. This is especially true because it reveals *early* cancer. That is, it demonstrates the lesion at a time when cure is easy and may be said to be certain.

AUTHORS' SERIES

In the course of several thousand examinations, Doctors Papanicolaou and Traut found 193 instances of carcinoma of the uterus—about 126 lesions involving the cervix and of both squamous and the adenocarcinomatous varieties; the rest, sixty-seven, carcinomas of the fundus. The smear showed the presence of cancer of the cervix in all but 1.3 per cent of the instances when it was demonstrable by biopsy. The failures to diagnose were due to postradiational effects with partial healing in one case and, in another, to excessive bleeding which was so profuse that it washed all the cells out of the vagina. However, there were thirteen instances of adenocarcinoma revealed for the first time by the vaginal smear when no other clinical procedure had sufficed to make the diagnosis. Some of these were very early lesions.

COMMENT

It is clear, therefore, that the vaginal smear is the best of any single available method. And that as far as early carcinoma of the cervix and silent carcinoma of the fundus are concerned, it is far superior to biopsy.

However, in view of the fact that the method is subject to some fallacious deductions, and also because it will be a long time before any considerable number of microscopists can be trained to a degree of dependability in diagnosis, we recommend the use of the vaginal smear as an "indicator method," and the biopsy as the final step necessary to the making of the final diagnosis.

We feel that the application of this method will bring about a great increase in the number of early diagnoses of carcinoma of the uterus and that as a result a great improvement in the "cure rate" of carcinoma of the uterus may occur. In addition, many unsuspected older lesions of the cervical canal and fundus of the uterus will be discovered; and, although these are not so amenable to treatment as the early lesions, they will be brought under the influence of therapeutic procedures sooner than would otherwise have occurred, with improvement in results in this group as well.

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MEDICAL EPONYMS

Politzer Bag

Dr. Adam Politzer (1835-1920), while *Docent* in otology at the University of Vienna, presented a discussion, "Über ein neues Heilverfahren gegen Schwerhörigkeit in Folge von Unwegsamkeit der Eustachischen Ohrtrompete [On a New Therapeutic Procedure in Deafness due to Blocking of the Eustachian Tube]," in the *Wiener medizinische Wochenschrift* (13:84-87, 102-104, 117-119 and 148-152, 1863). A portion of the translation follows:

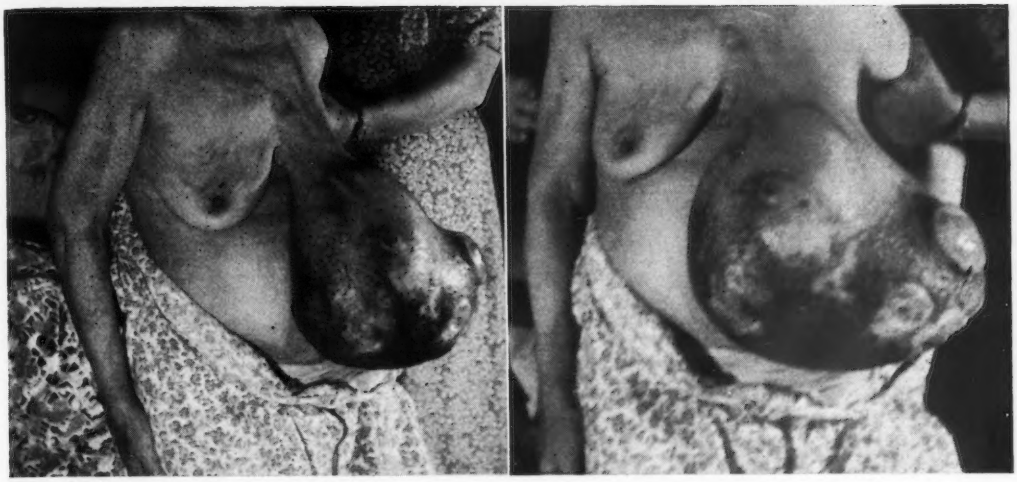
"The seated patient holds a little water in his mouth . . . and is told beforehand to swallow it at a given signal. The instrument used consists of a straight or slightly curved metal tube shaped like a catheter; or better, a rubber tube of rather large caliber, connected with a pear-shaped rubber bag about twice as big as a man's fist. The physician, standing preferably at the patient's right side, inserts the anterior end of the tube 1.0 cm. into the proper nostril, compresses the ala nasi (so that no air can pass over the instrument) with his left thumb and index finger, and with his right hand vigorously expresses air from the bag into the nose while the patient swallows."—R. W. B., in *New England Journal of Medicine.*

* * *

Eustace Smith Sign

This sign, although not unanimously accepted as valid, is still frequently referred to. It was described by Dr. Eustace Smith (1835-1914), physician of the East London Children's Hospital, in a communication entitled, "On the Diagnosis of Enlarged Bronchial Glands in Children" (*Lancet,* 2:240, 1875). He writes:

"The symptoms by which enlargement of the bronchial glands can be distinguished . . . are all pressure signs due to the encroachment of the swollen body upon the parts around. . . . At an earlier period, and before the enlargement has become . . . great . . . much assistance can be gained from the following experiment. If the child be made to bend back the head so that his face becomes almost horizontal and the eyes look straight upwards at the ceiling above him, a venous hum, varying in intensity according to the size of the diseased glands, is heard with the stethoscope placed upon the upper bone of the sternum. As the chin is now slowly depressed, the hum becomes less loudly audible, and ceases some time before the head is brought back again into the ordinary position."—R. W. B., in *New England Journal of Medicine.*



Figs. 1 and 2.—Malignant tumor of left breast.

MALIGNANT TUMOR OF BREAST

E. G. Motley, M. D.
AND
D. A. Harwood, M. D.*
Santa Ana

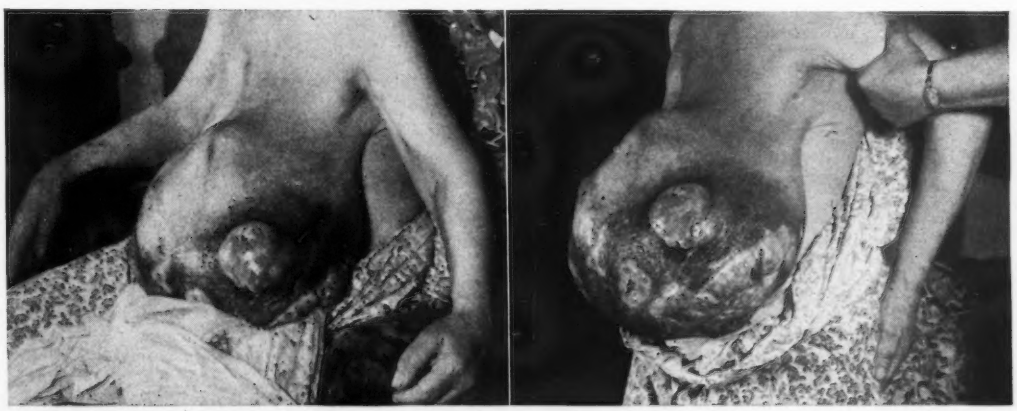
Mrs. Anna K., widow, age 67, height 5 feet, 3 inches, weight 170 pounds. Born in Germany of poor parentage, family consisting of nine children. An uncle in America sent for her and two brothers, and they came to America and settled in Kansas. Father died at age 85 and mother at age 67. The other children in Germany she does not know about; but, as far as she knows, the two brothers in America are alive. She has grown up and lived on a farm in Kansas until about three years ago, when she came to California. She had the usual diseases of childhood without any special complications. She had pneumonia when about 40 years old, but general health has been good.

She was married at age 24, has three children living and well, one baby stillborn. She nursed her children, and after the youngest was weaned she noticed a small lump in the left breast which was about the size of a small walnut. She thought it had something to do with "caking" of the breast, so said nothing about it to anyone. However, it seemed to grow as time went on and gradually became considerably larger. Then she was afraid to say anything about it, as she dreaded any operation, having known a woman who had died following a breast amputation. It continued to increase in size, and about a year ago the surface broke on the most dependent part. Her daughter came for some advice as to what to do with it, but said her mother refused to allow any doctor to see her or treat her.

The denuded and broken-down surface spread and the necrotic area developed into a more extensive surface and a serosanguineous-purulent discharge became very copious and foul-smelling, and she required considerable attention from the family. Finally, a neighbor persuaded her to have medical advice and so she came under supervision.

She entered St. Joseph's Hospital on the evening of May 2, 1943, and on the following morning, under light anesthesia of intravenous pentothalsodium, Dr. D. A. Harwood and Dr. E. G. Motley removed this entire mass. By lifting it up so the base was held taut, clamps were placed across the base and it was removed. The removed mass weighed twenty-two pounds. Vessels were clamped and tied and retention sutures put in and the skin closed with dermal sutures. There was an uneventful recovery and the patient left the hospital in four days. She is quite well now, no edema of the arm, and no pain or soreness. She is very active again (June, 1943), gaining in weight and strength; feels better than she has for many years.

* Editor's Note.—The death of Dr. D. A. Harwood, president of the Orange County Medical Society, occurred on July 17, 1943. Obituary tribute appears in this issue.



Figs. 3 and 4.—Malignant tumor of left breast.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

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OFFICIAL NOTICE

Proposed Amendment to Article IV, Section 1 (c) of the Constitution of the California Medical Association. (See June, 1943, "California and Western Medicine," Reference No. 5, on page 349.)

Section 1 (c) of Article IV of the Constitution of the California Medical Association is hereby amended by adding, immediately after the first paragraph contained in said Section 1 (c), a full new paragraph:

If an application for retired membership is submitted by a component medical society within the calendar year immediately succeeding the last calendar year in which the recommended applicant was an active member in good standing, the Council shall have authority to act on such application as though it had been submitted in the preceding calendar year during which active membership existed.

So that the said Section 1 (c) of Article IV will, therefore, read:

(c) Retired Members

Qualifications.—Retired members of the California Medical Association shall be elected by the Council on the recommendation of any component county society from those active members thereof who cease the practice of medicine for reasons satisfactory to such component county society and the Council, and who shall have been active members of the Association for ten years or more prior thereto.

If an application for retired membership is submitted by a component medical society within the calendar year immediately succeeding the last calendar year in which the recommended applicant was an active member in good standing, the Council shall have authority to act on such application as though it had been submitted in the preceding calendar year during which active membership existed.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Armed Forces Must Have Six Thousand More Physicians by January 1*

The Medical Profession Is Expected to Fully Meet the Responsibility That Has Been Placed On It

The armed forces must have six thousand additional physicians by January 1, 1944, *The Journal of the American Medical Association* reports in an editorial on page 1016 in its August 7 issue. *The Journal* says:

"At a conference of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, held on July 31, with the War Participation Committee of the American Medical Association and in the presence of Mr. Paul V. McNutt, chairman of the War Manpower Commission, and representatives of the Army and Navy medical departments and the Public Health Service, it became apparent that the medical profession must produce toward the winning of the war an

* For full text of the War Manpower Commission directive of June 7, 1943, concerning physicians under age of 45, appeared in the July issue of CALIFORNIA AND WESTERN MEDICINE, on page 78. Editorial comment in the same issue, on page 2.

additional six thousand physicians for the armed forces before January 1, 1944. Pursuant to a realization of this objective, a directive has gone to the generals in command of the various service commands authorizing them to induct into the service physicians between the ages of 38 and 45 who have been declared available by the Directing Board of the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians and who are otherwise subject to Selective Service.

"The needs of the armed forces are real. The members of the War Participation Committee raised with the representatives of the various governmental agencies all the questions that have from time to time challenged the need; the challenge seems to have been met effectively. Indeed, the intimation was made clear that the needs of the armed forces will be met by specific regulations of the Selective Service Administration or the enactment of necessary legislation if required. All physicians up to 45 years of age who have been indicated as available have, therefore, placed on them now the responsibility for an immediate decision as to their enlistment with the armed forces. The need is so positive that questions of essentiality of men in positions of teaching and research and in industrial medicine are likely to be rigidly reviewed in the near future with a view to extracting from civilian life everyone that can be spared.

"As the war continues and intensifies, new needs for the services of the medical profession become apparent. An army in motion and one engaged in the kind of aggressive combat that now concerns our armed forces needs physicians in even greater numbers than have heretofore been demanded. Many thousands of interned aliens and prisoners are now the burden of the United States and must be given medical care.

"If there is any physician who still hesitates under these circumstances, he should realize the added advantage to him of accepting now the commission that is proffered. Should it become necessary in the near future, as seems quite likely, to enlist new activity by the Selective Service Administration and the Officers' Procurement Service to bring in the six thousand physicians that are so certainly required, those recruited by that technique will inevitably begin their service with the minimum commission that is offered, namely, that of first lieutenant. Until that technique is installed, the men of special competence and of years beyond those of the recent graduate have the assurance of careful consideration and a commission more nearly in accord with age and experience.

"The call here made has the approval of the Directing Board of the Procurement and Assignment Service and of the War Participation Committee of the American Medical Association. The medical profession may well be proud of the fact that it has been the only group given, by directive of the President, the responsibility of maintaining service in civilian life and at the same time supplying the needs of the armed forces. Let us not fail in meeting fully the trust that has been placed upon us."—*The Journal of the American Medical Association*, August 7, 1943.

Burns and Wound Infections in Air Raid Casualties: New Recommendations

The Medical Division of the Office of Civilian Defense has revised its pamphlet, "Treatment of Burns and Prevention of Wound Infections," to incorporate new techniques that have been developed within the past year. The recommendations in this pamphlet are based on recent directions of the Committee on Chemotherapeutic and Other Agents and the Subcommittee on Burns of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. Originally drawn up by these committees for the armed forces, the recommendations have been modified to adapt them to the problems involved in the treatment of civilian casualties.

Recommendations for the use of sulfonamides are accompanied by the observation that these drugs must be used more cautiously in the treatment of civilian wounds than is necessary in the care of military casualties for the following reasons:

"The injured may include individuals of all ages and with various types of preëxisting disease, instead of a selected group of healthy young males. The possibility of toxic effects is therefore greatly enhanced. Moreover, it is assumed that in civilian injuries, hospitalization will be possible in a relatively short time, whereas in military operations such is not always the case. This usually makes it possible to postpone all consideration of chemotherapy until the injured have been hospitalized. It is then possible to administer sulfonamides with better safeguards and to consider such contraindications as other pathological conditions or known sensitivity to individual drugs. The dangers of dehydration can also be better prevented or overcome under such circumstances."

In a discussion of intra-abdominal wounds leading to perforation of the hollow viscera, the revised pamphlet advises sodium sulfadiazine as the drug of choice for parenteral administration, which is considered preferable to oral therapy during the first forty-eight hours. Sulfanilamide was recommended in the previous edition. Concentrated solutions of sodium sulfadiazine are not recommended for subcutaneous or intramuscular routes, but it is pointed out that weak solutions (0.5 per cent) may be used with little danger of sloughing of the tissues.

Special emphasis is placed on the danger of giving sulfonamide drugs to a patient who is not voiding normally (over 1,000 c.c. per day).

"Should circumstances require sulfonamide administration in the presence of inadequate urinary output, the urine should be watched for evidence of renal damage and the dosage of drug adjusted so that a blood concentration, as evidenced by daily determinations, not to exceed 10 milligram per cent, is maintained," the pamphlet warns. "If further diminution of the urinary output occurs, administration of the drug should be stopped immediately and fluids should be forced orally, if possible, and by means of glucose and water (5 per cent in sterile distilled water), intravenously if necessary. If anuria due to bilateral obstruction of the ureters develops, ureteral catheterization and lavage of the renal pelves may be required."

The emergency care of burns is outlined as follows:

"Whenever casualties with extensive burns can be admitted to hospitals without delay, and definitive treatment can be instituted promptly, morphine sulphate, one-half grain, should be administered at the scene of the incident and no local therapy applied to the burned area except sterile gauze to exposed surfaces to prevent infection."

The most notable change in the Office of Civilian Defense pamphlet is the withdrawal of the recommendation of the use of ointments or jellies containing tannic acid in the first-aid treatment of burns. The new advice given is that when definitive care cannot be carried out within two hours, the patient should receive sufficient morphine to relieve pain (not less than one-half grain, except in patients with lung and bronchial damage, the very old or the very young); and the burned surfaces should be covered with sterile boric acid ointment or petrolatum over which one or two layers of gauze of fine mesh (44) is to be smoothly applied. Over this dressing thick sterile gauze or sterile cotton waste is to be placed and the entire dressing is to be bandaged firmly, but not tightly. Substitution of jelly containing 5 per cent sulfathiazole in water-soluble base, which is supplied in the Office of Civilian Defense carrying case A for Mobile Medical Teams, is permissible.

The discussion of definitive treatment of burns has been expanded to stress the necessity for administration of large amounts of plasma.

"In patients with severe burns, quantities up to twelve units or more may be required in the first twenty-four hours," it is pointed out. "To the patient in critical condition, plasma must be given rapidly (as much as 500 c.c. in ten minutes may be necessary) and not allowed to flow

drop by drop. It must never be administered by any other than the intravenous route. Syringe injection may be used. If facilities for hematocrit determinations are available, the following general rule can be used for guidance regarding the amount of plasma required. For each point that the hematocrit is above 50 per cent cells, at least 100 c.c. of plasma should be administered. If clinically satisfactory results are not obtained with this dosage, larger quantities should be given."

A footnote points out that rapid administration of intravenous fluids may be dangerous to cardiac patients and that the physician's judgment will have to determine the amount as well as the rate of administration in such cases.

The pamphlet describes "open" and "closed" treatment for burns. The "open" treatment which is now considered the treatment of choice and is especially recommended for treatment of burns of the hands, face, feet, perineum and genitalia, consists essentially of the application of boric acid ointment or petrolatum, with pressure dressings. Such dressings can often be left in place twelve or fourteen days.

The "closed" treatment, which is the tanning or eschar method, is particularly indicated in extensive "flash" or second-degree burns of the trunk. This method is recommended only if the following conditions are present: (1) If not more than twenty-four hours have elapsed; (2) if the burned area has not been grossly contaminated; (3) if strict surgical asepsis is employed in the preparation of the burned surface; and (4) if coagulation is rapidly accomplished, *i. e.*, by combined use of tannic acid and silver nitrate. The method of tanning is described as in the original edition of the pamphlet.

In the new directions, additional emphasis is placed on masking of both the patient and his attendants in order to minimize the danger of secondary infection.

Office of Civilian Defense Advises Gas Cleansing Stations at Hospitals

Hospitals should make complete plans for the immediate establishment, when needed, of "gas cleansing stations" for the care of injured persons who have been exposed to war gases, the Medical Division of the Office of Civilian Defense advises. Large communities should establish at least one gas cleansing station without delay for training purposes.

The Office of Civilian Defense recommends that the term "gas cleansing" be used to describe the procedure of removing vesicant liquids from persons and that the term "decontamination" be reserved for areas and objects.

The primary purpose of gas cleansing stations is the protection of hospitals and casualty stations and their staffs and patients from contamination by injured persons who have been exposed to vesicant agents. Contaminated persons who are not disabled are expected to cleanse themselves in the nearest private home or in other local facilities.

Existing facilities in casualty receiving hospitals must be converted into gas cleansing stations, it is pointed out, since under present conditions of scarcity of materials and man power, construction of new facilities is generally not justified. Hospital facilities that should prove suitable are: hydrotherapy rooms, nurses' or internes' locker and shower rooms, part of the outpatient department, garages or other separate structures. In the event these are not available, facilities to care for persons who are both injured and contaminated must be arranged in schools, gymnasiums, swimming pools, shower rooms, clubhouses, and community centers.

Cleansing stations should be equipped to take care of one-third to one-half of the hourly casualty receiving capacity of the hospital to be served, the Office of Civilian Defense recommends. The professional staff will consist of mobile medical teams assigned when the station is activated, supplemented by additional attendants from the Emergency Medical Service. In addition to cleansing and emergency treatment, the staff of the gas cleansing station will assist in undressing the injured, moving stretchers, caring for clothing and valuables, maintaining supplies and dressing wounds.

It is recommended that cleansing stations be established at or near hospitals and casualty stations which they are to serve. Every hospital that may be required to handle an appreciable number of casualties should have access to such cleansing station facilities.

The local Chief of Emergency Medical Service is responsible for the development of these stations, with the advice of the senior gas officer of the community.—*The Ohio State Medical Journal,* July.

Concerning Physicians Essential for Civilian Practice

A boxed card with black-face caption, appearing in the Tulare *Times* of July 9, contained the following text:

NOTICE TO THE PUBLIC

Every person under the age of forty-five in Tulare County practicing any branch of the healing art, as licensed by the State of California, has in his possession, if he has been made essential to the medical needs of his community, a letter stating the facts and that he is not available for military service. This letter will be signed by the Chairman of the Tulare County Procurement and Assignment Committee for physicians and surgeons.

TULARE COUNTY MEDICAL SOCIETY.

Six Thousand Service M. D.'s Needed

Chicago, Aug. 5.—(UP).—The armed forces must have six thousand additional physicians by January 1, *The Journal of the American Medical Association* announced today.

To achieve this goal, generals in command of the various service commands have been authorized to induct physicians between the ages of 38 and 45 who have been declared available by the directing Board of the Procurement and Assignment Service for physicians, dentists, and veterinarians, *The Journal* said.—San Francisco *News,* August 5.

Health Protection for Welders and Burners

Although the health of welders is, in general, good, there are some health hazards associated with welding, and those may be minimized by proper precautions. This bulletin contains a general summary of the more important occupational health problems of welders and the measures necessary to safeguard their health.

Eye Irritations.—Flying particles of slag or hot metal, and welding rays may irritate the eyes. Such injuries can be largely prevented by using the proper type of goggle. Safety goggles will protect the eyes from flying particles. Colored glass will prevent "flash burns." These colors have been standardized, and shades recommended for particular types of work are commercially available. The lighter shades protect from occasional indirect exposures, but will not protect from the direct glare of a welding arc. These should be worn underneath the welders' hoods, to afford protection while inspecting welds. The higher shades are used in welding helmets and goggles to protect the eyes from direct exposure while burning or welding. Metal or canvas shields should be provided around welding operations wherever practicable, and care should be taken not to weld while an unprotected worker is facing the arc.

Burns.—Welding rays may cause an artificial sunburn. This may be prevented by protective clothing and helmets.

Metal Poisoning.—Zinc fumes from welding on galvanized iron may cause metal-fume fever; lead fumes from lead cutting, or burning of lead-painted metal may cause lead poisoning. Metal poisonings can be prevented by local exhaust equipment so constructed as to remove the fumes at their source (exhaust openings must be placed within a few inches of the operator), and by the use of approved metal fume respirators or air line respirators.

Gas Poisoning.—Gases produced by the arc or acetylene torch may cause injury, but this ordinarily occurs only when welding is done in an enclosed space. Under such conditions an airline—or air-supplied respirator should be worn by the welder, unless adequate exhaust and ventilating provisions have been made.

OCD Plan for Emergency Medical Service in Industrial Plants

Every plant medical department should prepare a "disaster operations plan" to provide adequate medical service in case of a plant catastrophe involving large numbers of casualties. This is the advice presented in a new bulletin, "Emergency Medical Service for Industrial Plants," issued by the Medical Division of the Office of Civilian Defense (M-7047)....

Pointing out that plant medical departments are not ordinarily staffed or equipped to provide medical service for the large number of casualties which may occur in a major disaster, the bulletin outlines arrangements which should be made to assure adequate medical care at such times.

The disaster operations plan should provide for necessary first aid care at the site of the incident, for adequate ambulance service, and for hospitalization of the seriously injured, the bulletin advises.

Provision must first be made for casualty stations. Several sites should be selected, in order that alternative locations may be used in case those of first choice are destroyed or rendered unserviceable. An additional site outside the plant should be selected for use in the event of extensive damage to the plant, such as might occur in a bombing or explosion.

The importance of identification and records is especially emphasized in the bulletin.

"In any disaster confusion will be inevitable," it is pointed out. "It will be difficult, without adequate records, to identify the seriously injured and the dead and to determine the number and names of the missing. The uninjured as well as the injured should be accounted for. A record should be made of every person who leaves the plant. The record should indicate the places to which the injured have been taken."

In a consideration of transportation, the bulletin recommends that arrangements be made with the local Chief of Emergency Medical Service to insure that ambulances under his direction will be made available to the plant should a disaster involve the entire community. Similarly, any ambulance facilities owned by the plant should be made available to the local Chief if they are not required at the plant.

Present plans for the hospitalization of industrial accident victims are likely to be grossly inadequate in the event of a major plant catastrophe, the bulletin declares. Large numbers of patients should not be sent to one hospital, if other hospitals are available. To provide quick and efficient service to injured persons, casualties should be distributed among various hospitals. Arrangements must be made with the local Chief of Emergency Medical Service for the admission of casualties to community hospitals, all of which will be under his supervision during a major emergency.

A prerequisite to the entire plan of mutual aid between a plant and a community is a definite understanding that members of the Emergency Medical Service will be admitted promptly to a plant in an emergency. To assist plant managers to carry out their duty in keeping unauthorized persons out of war production plants and to facilitate the admission of physicians when they are needed, the Service Commands of the Army are conducting investigations of the key personnel of the Emergency Medical Service. Personnel investigated and approved by the Service Command, will receive identification cards from the Office of Civilian Defense.

The bulletin sketches the organization and operation of protective services in a community, and the over-all protective services recommended for industrial plants. It also outlines the program of federal compensation for injuries to Civilian Defense workers and explains how this plan applies to industrial workers. A bibliography of pertinent material is included.

Government Chart: "Operation of Emergency Medical and Rescue Services"

An interesting chart was issued in August by the United States Office of Civilian Defense, Washington, D. C., as OCD Publication 7022.

The chart is sufficiently diagrammatic to warrant its placement on the bulletin boards of hospitals and casualty stations. Its inspection easily and rapidly orients the reader on the exact steps of procedure in caring for injured persons in case of an "incident." Its text follows:

"The *incident* (first illustration) is reported by the *warden* (second illustration) to the *control center* (third illustration). Local chiefs of rescue and emergency medical services at the center dispatch to the scene of the incident:

From *rescue depot* (fourth illustration), a rescue squad.

From *hospital* (fifth illustration) or *casualty station* (sixth illustration), one ambulance and one sitting-case car with one mobile medical team.

Ambulance takes major casualties to casualty receiving hospital. Sitting-case car takes minor casualties to near-by casualty station. (*Other services are dispatched similarly by the control center.*) Evacuees from hospital are removed by large bus or truck ambulances to *emergency base hospital* (seventh illustration) in rural area.

Central registry of *Emergency Welfare Service* (eighth illustration) received casualty information from hospitals, casualty stations, and morgues."

More New Homes: War-Working Alameda Opens Another Federal Housing Project

In war-working, industrially booming Alameda, 1,200 desperate workers have applied for apartments with the Alameda Housing Authority.

But there *is* a Housing Authority in Alameda which is building war apartments. And what does it mean to these war-working house seekers?

They Are Moving In

In cold, solid figures, it means that 4,902 dwellings are planned for them. Families have moved in and filled up ninety-five of these dwellings in the Pacific Project.

Opening up now is the Chipman Project. Twenty-two families are living there and more are coming in as each building is finished. Completely occupied, the project will be housing 760 certified Alameda war workers.

The Encinal Project, to accommodate 1,240 families, and the Webster Project, which will house 400, will open very soon.

Still in the planning stage, with no buildings up, are the Webster Number 2 Project, which will house 360 workers, and another project, now nameless, which will house 1,040.

Ground is now being broken for the Atlantic Trailer Park, which will accommodate 206 trailer families.

And that's all. Because Alameda will have no ground space left for other dwellings when these are completed.

There you have living quarters. As for schools, stores, child-care service and recreation, they, too, have been considered.

Health Service

As for health, the California Physicians' Service, which provides complete medical and hospital care on a coöperative basis and 24-hour doctor's care will be available.

The California Physicians' Service will go into effect as soon as 90 per cent of the tenants of any one project sign up for its services.—San Francisco *Chronicle*, June 4.

Medical Journals—For Colleagues in Military Service

In former issues, editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy, and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

University of California Medical Library, The Medical center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals via "Railway Express Agency," collect, to: California Medical Association Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from the California Medical Association. The Postgraduate Committee will forward to camps.

* * *

The covering letter, which follows, is sent forward with each shipment:

CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, San Francisco

To the Medical Officer in Command
At Army, Navy, or Air Force Station located in California at: ————————, California.

From: *California Medical Association Postgraduate Committee.*

Subject: *Medical Literature* (To be shipped to your camp).

Dear Doctor:

We shall shortly send to you, by prepaid mail or express, as per the above address, some medical journals or books.

These are not late editions, but they are, after all, medical literature.

When received by you, you are at liberty to place or dispose of them as you see fit.

They are contributions received from medical colleagues in civilian practice, and from the three medical libraries in California: University of California Medical Library (Medical Center, San Francisco); Stanford (Lane Library at 2398 Sacramento Street, San Francisco); Los Angeles County (Barlow Medical Library, 634 South Westlake, Los Angeles); in response to requests made in CALIFORNIA AND WESTERN MEDICINE in its issues of: September, on pages 169 and 201; October, on pages 230 and 250; November, on pages 286 and 315. (The facilities of these medical libraries are available to your staff members for "packet service.")

At some hospital stations, there is an ample supply of medical literature available. At others of the newer camps, there is practically none.

Your hospital station has also been placed on the complimentary mailing list of CALIFORNIA AND WESTERN MEDICINE.

We trust you understand the spirit in which these parcels are sent. They go forward to your respective camps with the good wishes of your civilian colleagues. If the undersigned can be of service, feel free to inform us.

Cordially and fraternally yours,

CALIFORNIA MEDICAL ASSOCIATION POSTGRADUATE COMMITTEE,
By GEORGE H. KRESS, M. D., *Secretary.*

Military Clippings.—Some news items of a military nature from the daily press follow:

15,000 Wounded Removed by Air

Chicago, July 15.—(INS)—Seven thousand stretcher cases were evacuated by airplane from battle areas in Algeria in April, the *Journal of the American Medical Association* reported today in a story from its London correspondent.

More than 15,000 wounded were taken to Oran, Algiers or Gibraltar by aircraft equipped as ambulances, according to the correspondent.—Los Angeles *Examiner*, July 16.

Scarcity of Doctors

With the number of women doctors in this country now numbering many thousands, it seems strange that so few of them are in army service. Although they fought for the privilege, they are hardly enlisting at all. A report issued on July 1 indicated that only four had actually received officers' commissions. It is suggested at Washington that the women physicians do not realize how much they are needed, with the army 7,000 short of the requirement for essential care of soldiers.

The army heads emphasize the fact that no distinction is made between men and women doctors, and both are wanted. The women have the same rights as the men, and must meet the same professional standards, and are assigned wherever they are most needed. Doctors may have to be rationed.

One reason, presumably, why the women are slow to join the army medical service, is that with so many men doctors already gone to join the armed services there is a great lack of physicians on the home front, and the women think it their duty to serve on that front. They might be right about it.—Berkeley *Gazette*, July 20.

Army Reports Quick New Venereal Disease Cure

Brigham (Utah), June 23.—(AP)—Rapid strides in the postwar cure of gonorrhea through use of a new yeast-like fungus called penicillin was envisioned today by doctors at the Army's Bushnell Hospital.

Lieut. Col. Henry G. Hollenberg, chief of the surgical service at the hospital, and Lieut. Col. Frank B. Queen, chief of the laboratory, reported the new drug—available only to the Army—cured twelve of fourteen cases of gonorrhea within thirty-six hours and satisfactory results were obtained in the others.

Other Drugs Failed

The doctors said all fourteen of the infected men had failed to respond to other treatment, despite an average hospitalization of fifty-two days and the use of many other drugs, including the sulfa type.

Hollenberg admitted the results were astounding, but was reluctant to predict what effect the new discovery would have on the prevalency of venereal disease when the medicine becomes available to the public after the war.

Queen, however, said the Army's tests at Bushnell spoke for themselves.

Queen said use of the drug throughout the Army, when it becomes available in such quantities, would reduce hospitalization from weeks to a few hours or days. . . . —San Francisco *Examiner*, June 24.

Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Doctors desiring to go into the Army may have their papers prepared and receive orders for physical examination from the Officer Procurement Service, 328 Flood Building, San Francisco, in charge.

From any of the fourteen southern counties, they may apply to the Officer Procurement Service, 1418 U. S. Post Office and Courthouse Building, Los Angeles, Major M. L. Murrell, in charge. Telephone: MAdison 7411, Extension 684.

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U. S. N. The Senior Medical Officer is Capt. Philip K. Gilman, U. S. N. R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone: EXbrook 3386, Local 46.

The Naval Office of Procurement for the southern section of California is in charge of Admiral A. Johnson, U. S. N. The Senior Medical Officer is Captain John C. Ruddock, U. S. N. R. The office is located at 411 West Fifth Street, N. W. Corner of Hill, Los Angeles. Telephone: MIchigan 8641.

Army Draft Cut; 287,000 Women Needed

Washington, June 18.—The Army as of now plans a net increase of only 1,020,473 persons in its uniformed personnel during the twelve months starting July 1, and more than a quarter of that increase will be women.

The figures appeared to foretell a sharp decrease in the rate of inductions, and possibly a postponement of the time when general drafting of fathers will start. . . .

Major General H. K. Loughry, Army chief of finance, presented a table showing that the Army is planning to have to pay a peak of 8,233,083 uniformed persons during the 1944 fiscal year. That peak load includes 7,801,224 men—603,022 officers and 7,198,202 enlisted men; 375,000 WACs, including 40,202 officers; 51,177 women nurses, 2,900 female dietitians and 2,782 women physical therapy aides.

The increases contemplated by those figures above the peak for the current fiscal year—a peak which undoubtedly will be June 30, the last day of the year—included 698,202 enlisted men and 35,178 men officers; 28,406 WAC officers and 236,561 enlisted WACs; 19,278 nurses, 1,452 dietitians and 1,396 physical therapy aides.

Thus, Selective Service will be called upon to furnish 733,380 men after June 30, plus replacements for men killed in battle or who leave the service for other reasons. It was noted, however, that since the table included pay for all uniformed Army personnel, nonfatal casualties apparently will not be replaced above the increases noted.

Recent testimony by naval officers before another appropriations subcommittee in connection with the Navy supply bill revealed that it plans a net increase of 802,397 persons in its uniformed personnel, including women's reserves. It included a net increase of 775,192 men.

The increases of 775,192 men for the Navy and 733,380 men for the Army mean that 1,508,672 men—plus, presumably, replacements for fatalities—will be called into the two services during the next year.

That would be an average of approximately 125,000 men a month. But since the Army presumably will take most of its additional men during the next six months, the induction rate may well level off at 100,000 or less a month after January 1.—San Francisco *News*, June 18.

Three Physicians "Buddies" in Army

The unusual circumstance of three men who were associated closely in civilian life being assigned to the same place in Army service is noted in the case of Dr. Philip Corr, Dr. Ray B. McCarty and Dr. E. D. Quick, all of Riverside, now at Hoff General Hospital in Santa Barbara.

Doctor Corr, who went into the Army about two years ago as a major, recently was promoted to the rank of full colonel. He is director of the medical division and chief of medical service.

Major McCarty is chief of the general surgery section, while Captain Quick is chief of the out-patient department. The families of all three men now are living in Santa Barbara. Colonel Corr and Major McCarty were on the program of the California Medical Association this week in Los Angeles.

Colonel Corr has been at the base hospital ever since it was established to take care of service men stationed in the Southland.—Riverside *Enterprise*, June 12.

Navy Lease on Two Big Hotels Confirmed

Yosemite, Sun Valley to Get War Wounded, McIntire Says

Rear Admiral Ross T. McIntire, Navy surgeon general and White House physician, on June 2 confirmed reports that the Navy will lease Ahwanee Hotel in Yosemite Valley and properties in Sun Valley, Idaho, as quarters for convalescent wounded.

Men will begin moving into Sun Valley's 1,400 beds within two weeks, and the Ahwanee's 1,000 accommodations are immediately available, he said.

On a tour of hospital bases, and to "observe certain patients from the South Pacific," Admiral McIntire said he was "seeing a very different type of case from those of the last war."

"This is due in part to the violence of this war," he said. "Another of our problems is malaria, and it is very, very serious. Not only do we have it in the Pacific, the Army shares it in Africa. A high number of men are being immobilized by it.

"While we had 8 per cent fatalities among wound cases in World War I, our record as far as deaths from battle wounds are concerned now is only about 2.1 per cent.

"This is due, I think, in part to the way we handle cases, with no more long trips by ambulance. We have better methods for shock treatment, with the blood substitutes, and the sulfa drugs. In addition, officers and men know or are taught first aid."

Commenting on lowering of Navy physical standards for the first time, as ordered recently, Admiral McIntire said men with defects in sight, hearing, or in their legs and hands, may be used on limited duty, but not as a combat class.

Admiral McIntire, who planned to visit Mare Island and Treasure Island today, will complete his bay area inspection tomorrow, leaving here tomorrow night.—San Francisco *Call-Bulletin*, June 2.

Life Saver in Tunisia: Blood Plasma Led in Keeping Death Rate Low

Chicago, June 7.—Major General Norman T. Kirk, Surgeon General of the Army, told the American Medical Association House of Delegates today that the American wounded death rate in Tunisia was "unbelievably low."

The rate was two-and-one-half to three-and-one-half per cent, for the Americans' first campaign before they moved north to attack Bizerta. These are the first official figures. They are higher than in some other fighting, but are miraculous because of the long distances the wounded had to be carried. In World War I under like conditions deaths would have been 15 to 18 per cent.

General Kirk was personally through the Tunisian campaign until after the German surrender. He was appointed Surgeon General after his return to the United States, June 1.

In Tunisia, said General Kirk, the wounded had to be carried on the average eight to twenty miles through mountains to the first medical stations, and after that another 650 miles by ambulance to evaculation hospitals. Later there was another 400 to 500 miles back to base hospitals.

Planes, which carried war supplies to the front, brought back 13,000 men to hospitals, including both battle casualties and the sick.

Sulfa drugs were definitely not the first reason for the saving of lives, General Kirk asserted.

The foremost life saver was plasma, the dried blood extract which millions of Americans have been giving the Red Cross for nearly two years. Plasma saved shock and bleeding, and without that General Kirk said many men would have died before they could reach medical care.

Second in life saving was surgery, which cleaned up the wounds to reduce risk of infection. In third place were the sulfa drugs, aiding to minimize infections.

In this southern campaign an unbelievable record was a total of only seventy-seven cases of bone infection. That trouble afflicted 75 per cent of the wounded in previous wars. The seventy-seven cases were an almost astronomically small fraction of 1 per cent of wounded.

Gas gangrene, another killer, caused just one death, and there were only twelve cases altogether.—Howard W. Blakeslee in San Francisco *Chronicle*, June 8.

Hotel Will Be Ready Soon as Army Hospital

Conversion of the Vista del Arroyo Hotel in Pasadena into an Army hospital is rapidly nearing completion and the first patients are expected to be received about July 1, it has been announced by Lieutenant Colonel W. C. Williams, executive officer. . . . The hospital will provide care for soldiers stationed at Camp Santa Anita and other area Army posts, it was stated.

Colonel Williams, a veteran of thirty-three years' service in the Army Hospital Administration, predicted that the hospital, surrounded by broad terraces, swimming pools and other recreational facilities, probably will become one of the most important convalescing units in the country.

Staff members who have reported for duty include First Lieutenant Dora A. Noble, principal chief nurse; Major Gordon K. Smith, chief of surgical services; Captain George T. LeClercq, chief of x-ray services; Major Perry J. Melnick, chief of laboratory services, and Lieutenant Colonel Rolph P. Chessal, chief of dental services.—Los Angeles *Times*, June 3.

Evacuation from Battle

Wonder has been expressed as to what the Allied armies in Tunisia can do to feed and care for the great host of over 200,000 enemy captives. To do this is a normal function of armies and is planned for well in advance.

In army operations, there are two great services that go on behind the fighting lines. One is the forward movement of food, ammunition, reinforcements, replacements, and it is called "the Service of Supply." At the same time, a rearward movement takes place, organized carefully and fully provided for. It is called "evacuation." It is the daily transport from the fighting front to positions far in the rear, of the wounded, the sick, of guns and equipment that require repair, captive property that can be salvaged; and it is the transport of prisoners.

The whole object of a well organized system of evacuation is to free the fighting forces of the impediment of broken men and broken material. It cannot be done too soon. It is normally done every night following battle. . . .

* * *

The other rearward movement of personnel are the casualties—the wounded, disabled, the men too sick to continue. This matter of medical evacuation is a whole subject in itself. It requires special organization and a series of different units working from the firing line far back into the rear.

Accompanying every battalion into action are surgeons and a small group of Medical Corps men. It is their business to give prompt aid to the men who fall. It is dangerous and heroic work, done under fire. The immediate care given to a man who is shot by a bullet or torn by a fragment of a shell is temporary only enough to stop his bleeding, to apply a tourniquet or an antiseptic bandage.

Instructions may differ now, but in the first World War, we were taught to leave the wounded man alone until he recovered from shock—let him lie quietly for a while, provided that his bleeding be staunched, that his thirst be slaked and his position made comfortable.

Soldiers today are trained not to fall out of the ranks to take care of a stricken comrade. They must keep advancing, and keep up their fire. The old picture of soldiers helping a wounded comrade to the rear represents obsolete form. It impairs the attack. It accomplishes no good.

* * *

From their position where they lie on the ground, wounded men are carried on stretchers by special units, called "bearer companies." They are carried a short distance rearward to positions where field ambulances are met. Here a man's injury is reëxamined, the bandage adjusted, if necessary. He may be given a stimulant, light food, an opiate, an antitetanus injection. Then he is moved back, this time by an "ambulance unit," formerly horse-drawn, now motorized, and carried some distance to the rear beyond the reach of artillery shelling, to the field hospital of the division. Even here, only necessary attention, immediately required, is given by the medical officers.

From this hospital in the field, wounded are evacuated as promptly as possible, by medical agencies sent forward from the Army. At this point, too, or even sooner, the nature of the man's injury is determined. If his wound is slight, he may even be marked for return to duty. If he can walk, he is a "walking patient," or a "sitting patient," or a "prone patient," according to his injury.

This process of sifting wounded and separating them according to their injuries is called by a French word that we picked up in the first World War, triage.

* * *

Medical regiments are a part of the troops that accompany all armies. There are "hospital regiments," some of them able to set up under canvas hundreds of cot beds, "surgical regiments" which can operate on wounded men whose condition is too serious to allow further immediate evacuation. Back of this organization are "base hospitals," "convalescent hospitals," and so on.

The system in use in the American Army is called the Letterman System and it has a rather curious history. Doctor Letterman was the surgeon general of the Army of the Potomac in the Civil War. His experience in the early battles of that war taught him that special organization was necessary if wounded men were to be saved and cured, and if the fighting forces were to be promptly relieved of their care and their presence. Letterman worked out a system. It was first used, I believe, in the Battle of Antietam, where the casualties were very large.—(Letterman Hospital in the Presidio at San Francisco was named in honor of Doctor Letterman.)—From an article by Major General David Prescott Barrows, military authority and former president of the University of California, in the San Francisco *Examiner*, May 21.

Learn by the experience of others; your own may come too late.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

How to Obtain a Physician in a Family Emergency

County Society Issues Recommendations to the Public Through a Press Statement

Under the above caption, the Westchester, New York, Medical Bulletin of July, 1943, issued a press statement that may have suggestive value to component county societies in California.

Westchester families were urged on June 7 to take steps to make sure they may be able to obtain necessary medical care in the event of a family emergency. The suggestion was in the form of a statement issued by the county medical society, in which the public was urged to communicate with the local hospitals if the family physician is not available at a time of emergency need. The statement follows:

"The Westchester County Medical Society has received reports indicating that occasionally Westchester families have encountered difficulty in obtaining the services of a physician, especially in the late evening or early morning hours. While there is a real shortage of physicians in Westchester, owing to the fact that one-third of the county's normal complement of doctors is serving with the armed forces, nevertheless, there are enough physicians in civil practice to care for all normal needs if the public will continue to coöperate with the profession and inform itself of the plans that have been made to meet emergencies.

"Most of the younger physicians normally available for work during the night are in the Army and Navy. The men remaining in civilian practice are older and more handicapped physically. They now are working harder than ever during the day-time hours, which makes it necessary for them to conserve their energy as far as possible and to avoid unnecessary interruptions of their rest. Local groups of physicians in all parts of the county are aware of this problem and have taken steps to make certain that everyone shall be able to reach a doctor when he needs one. In general, emergency arrangements are centered in the community hospital.

"The County Medical Society recommends the following steps:

"(1) Every person should become acquainted with some family physician in his community. The names of general practitioners, pediatricians or other specialists can be obtained by consulting the local hospital or the office of the Westchester County Medical Society in White Plains.

"(2) In emergency, if the family physician is not available the family should telephone the local hospital. If the emergency is acute the family may request the hospital to get in touch with a local physician and arrange with him to make the call at once. If the situation is not urgent, the hospital may be asked to give the names of several practitioners serving on the attending or courtesy staff of the hospital, and the patient himself can make the contact with the doctor.

"(3) If the patient lives in one of the larger communities, he may communicate with the local medical exchange or professional building where the telephone operator can put the patient into immediate contact with one of a number of local physicians.

"(4) During daytime business hours, the office of the Westchester County Medical Society will give advice on these matters. The society will not recommend individual physicians, but will give lists of physicians, either in general practice or in the various specialties in any part of the county.

"(5) In emergency, the worst way to reach a local physician is to start calling all the physicians listed in the local telephone directory. Many of them are in military service, many others are specialists not normally available for general practice, some will be out of town. In general, if your family doctor is not available, the easiest way to reach a doctor quickly is by calling the local hospital."

Poliomyelitis Precautions

Although infantile paralysis cases have increased alarmingly in California this summer, the disease is not con-

sidered at epidemic stage yet by medical authorities. However, there is every reason for utmost precautions on the part of the public to prevent its becoming so.

A few simple rules are advised by California State Health Director Wilton L. Halverson as follows:

Call a doctor at once on discovery of such symptoms as stiff neck, sore throat, sore muscles, headache, rise in temperature, or nausea.

Keep children away from crowds.

Avoid undue exposure to heat, cold, and fatigue.

Get plenty of sleep and food to build resistance.

These should be easy to remember and observe. Strict adherence to them may mean the saving of many child lives and avoid the maiming of many young bodies.—San Francisco *News*, July 13. (See also items on page 152.)

Concerning Poliomyelitis

This is the season for the start of infantile paralysis epidemics. The National Foundation has compiled the following suggestions which may be helpful to residents of areas where poliomyelitis is on the march.

During an outbreak of infantile paralysis, avoid overtiring and extreme fatigue from strenuous exercise. Avoid sudden chilling, such as would come from a plunge into extremely cold water on a very hot day.

Keep children away from large groups. Parents should reduce the number of associations between children and other persons. The policy should be one of staying at home. Discourage visiting and avoid parties, gatherings, crowds, and travel. It is the opinion of medical authorities that tonsil operations should be delayed until an outbreak is over.

Be alert to early signs of illness or changes in the normal state of health, especially in your children. Do not assume that a stomach upset or signs of a cold are of no importance. These may be among the first symptoms of infantile paralysis.

All children and adults sick with unexplained fever should be put to bed and isolated, pending medical diagnosis.

Call your physician at the first sign of sickness. Early diagnosis of any illness gives greater hope for recovery. In infantile paralysis, early good treatment may save lives and prevent permanent damage.

Don't become hysterical if cases occur in your neighborhood. The medical profession and the health department will be using every known safeguard. Poliomyelitis is a disease caused by a filterable virus. During an epidemic many persons become infected with this virus, but only a small proportion are made ill. In a still smaller proportion, the illness is accompanied by muscular weakness or some degree of paralysis. Not more than one individual in every 3,000 or 4,000 has a paralytic attack. In other words, in a community there are many more unrecognized infections or "carriers" of the virus than reported cases of the disease.

The virus may be given off from an infected person in droplets from the throat or in fecal excretions or in both. The ordinary conditions of everyday associations between people in a family or in a community afford opportunity for the virus to pass from one individual to another. This passage may be reduced, in some degree, or prevented by careful attention to personal cleanliness and hygienic habits that should always be observed.

While it is possible that the virus may at times be conveyed through the medium of polluted water or milk, or by flies contaminated with fecal material, these modes of transmission are thought to be rare. Nevertheless, be sure to use milk and water that are known to be safe. And maintain community sanitation at a high level at all times.

Attempts to stop the spread of the virus by closing places where people congregate have been unsuccessful. The resultant disturbance to community life is a disadvantage. Therefore, orders requiring the closure of schools, movies, churches, and swimming pools ordinarily are not worth while.

The spread of the virus in your community cannot be entirely prevented, nor can the disease be "cured," in the strict sense of the word, but much more can be done for the patient. So give your support to the public health authorities in their efforts to lessen the penalties which it imposes on some of its victims.—*National Foundation News.*

How to Select Your Doctor

How to choose a reliable, competent physician is a problem made more acute these days, with many of the strongest and best-trained doctors going—or already gone—into the armed services.

Also vast changes in population centers have come about with the development of war industries, and many people are finding themselves in totally new environments, without such familiar landmarks around them as their family doctors.

Consult Agencies

It is more important than ever that the working civilian population get satisfactory medical care, and that intelligent distinction between competent medical practitioners and quacks be made.

There are several impersonal agencies of information about doctors available to the questing public. Obviously, the license to practice is one of these. So are membership in county medical societies and permission to use the facilities of an accredited hospital. And, finally, the records of the American Medical Association in Chicago may be consulted and give full objective data about all its members.

Ethics Strict

Information of this sort may also be gotten from the secretary of the local medical society, which is a branch of the American Medical Association.

There are certain signals which the layman can observe in making his choice of a doctor. He should beware one who claims extravagantly successful cures with "secret" medicines. The various healing cults are not full-fledged physicians, and advertising is not acceptable practice among reputable physicians.

Doctors who talk glibly and persuasively may frequently mask incompetence with too much "charm," and those who strive to frighten patients and then mulct them with exorbitant fees are likewise not to be trusted. Last of all, it is important to consider the term of residence and quarters of one's doctor. Doctors who travel about rapidly from town to town are likely to do so out of necessity.

One of the best and most direct ways to receive recommendations as to a doctor lies in calling the director of the nearest accredited hospital and asking for such information. It is also possible, through the various files and publications of the American Medical Association for a doctor in one community to recommend one physician or several in another community.

With these suggestions at hand, the patient can make his own selection further on the basis of personality preference, since agreeable personal relationship between patient and physician is extremely important in promoting satisfactory recovery.

The patient may go even more deeply into the matter of personal recommendation, and inquire among his acquaintances as to who stands particularly high among the physicians themselves of the community. Mere size of practice is no reliable criterion of a doctor's excellence, since

the art of salesmanship may be the major factor here rather than the art of healing.—Dr. Thomas Masters, in San Francisco *News*, June 25.

Government Builds Big Hotel for Workers

Men and Women Both Living at Dormitory

A war-time city, complete from living quarters to barber shop, has been constructed by the Federal Government in the Los Angeles harbor area to house workers who have poured into the shipyards by the thousands to build transports, cargo vessels, and warships at the fastest rate in history.

A dormitory with rooms for 3,000 workers, the $2,341,437 project is known as Wilmington Hall. It is operated as a hotel by the Los Angeles Housing Authority, and until a short time ago was housing only men. Increasing employment of women in the big yards near by received official recognition early in May, when rooms for 500 persons were opened to women.

Largest Hotel in World

With 2,126 double and single rooms, all furnished, Wilmington Hall has been termed the largest hotel in the world. Its sixty-seven buildings spread over nearly forty acres of land. Besides actual living quarters, they include a community center with theater, gymnasium, music room, cafeteria, library, lounges, barber shop, laundry and cleaning shop, community store, and infirmary. A staff of 185 men and women gives complete hotel service.

Construction of Wilmington Hall was started May 30, 1942, three days after the Los Angeles Housing Authority had signed an agreement with the Federal Public Housing Authority to build and manage the place for the duration of the war.

The architect, Lewis Eugene Wilson, designed the hall as a war baby throughout. Most of the buildings are walled with plywood—not a critical material at that time—with board siding on the outside. Plywood does the job of both inside and outside walls in the community buildings where uncovered studs rib the exterior. Such substitute materials as plastic shower heads, faucet handles, tubing, and fittings were used wherever possible.

Walled With Plywood

Management methods also were designed from the war angle. Shipyard work and overtime puts a strain on a person's health. So a health plan to give each resident who needs it, diagnosis, surgery, and hospitalization was set up by the Housing Authority through a contract with the California Physicians' Service. Weekly charge of $5.60 for a single room and $4.10 per person for a double includes the health service. The 32-bed infirmary is staffed by ten nurses, a physician and two dentists.

Morale of the residents is another problem. Many men living in Wilmington Hall have left their families in Texas, Arkansas, Oklahoma, Nebraska or Iowa to migrate to the turbulent war center. A daily schedule of entertainment and recreation is worked out by a staff of five community service aides to help keep up the spirits of these war workers.

A big auditorium, 75 by 150 feet and shaped like an oil drum cut in half, can seat 1,218 persons for motion picture shows twice a week and stage shows at least once a month. When seats are moved out, the room becomes either a ballroom or a gymnasium. Five acres of land are devoted to baseball diamonds, handball courts, horseshoe pits, and archery ranges. A folksy newspaper is put out weekly by the residents..

The Housing Authority's agreement with FPHA lasts only for the duration of the war. When its necessity has passed, Wilmington Hall will either be torn down or sold to private bidders. It was constructed as expendable housing to meet a shelter need that resulted from America's demand for more ships than had ever been built before in the shortest possible time.—Wilmington *Press*, May 8.

Civilians Will Get Only 20 Per Cent of New Physicians

Only 20 per cent of the medical graduates each year can now be spared for care of civilians. The others will go into the military medical corps as long as the war lasts.

This prospect was sketched to the House of Delegates of the American Medical Association in Chicago on June 8 by Dr. James E. Paulin of Atlanta, the Association's new president.

The yearly total of new civilian physicians he estimated at about 1,200. To this he added about 600 who are being retired each year from military service. Against this the doctors who are left, mostly men over 45, are dying at the rate of 2,500 a year.

Urges Planning

This leaves a deficit of about 700 a year. To meet this, and the big shortage due to nearly half the active doctors already in military service, Doctor Paulin said plans should be made now for better use of the older physicians who have not been very active in medical practice.

It is the hope of organized medicine to have one doctor for each 1,500 persons in the United States. This compares with an average of two to four per thousand in many areas, and is much better than some rural communities which have seldom or never had more than one doctor for 2,500 to 3,000 persons.

Doctors' Studies Curbed

The war has cut off the ordinary opportunities of physicians to keep up with advances and discoveries in medicine. To meet this, Doctor Paulin said the service hospitals of the Army and Navy all over the country are being opened to graduate medical meetings where doctors can learn and exchange new information.

He said that for the duration there is likely to be a falling off in studies on many diseases, particularly arteriosclerosis, heart disease, arthritis, cancer, and mental diseases. He recommended that doctors returning from war service be encouraged to undertake investigation of these diseases.—Fresno *Bee*, June 9.

Taking Dentifrice Ads to the Cleaners

Advertising men have done such a good job of selling dentifrices that millions of American medicine cabinets are cluttered with tubes and cans and bottles, bought in the belief that their contents will lend a sparkle to teeth, and claims have been so extravagant that the Federal Trade Commission, whose job it is to protect the public against falsification in advertising, has had to crack down several times during the past few years.

It has issued complaints against . . .

These representations are not only false and deceptive, charged the Federal Trade Commission last April, but they unfairly defame and disparage competing products. While most dentifrices contain mild abrasives, they do not cut cavities nor harm the teeth. . . .

In proceeding against these various companies, the Federal Trade Commission was not opposing the legitimate advertising of their products. The Commission is determined, however, that manufacturers shall cease misrepresenting them. . . .

The best way to clean your teeth is to give them a good brushing, using an up-and-down motion so that you reach

all exposed surfaces. The Council on Dental Therapeutics says that an inexpensive tooth-cleaning material can be made at home: one part of table salt plus three parts of baking soda. There is no objection to the use of most dentifrices, if you prefer their taste to that of salt and soda, but do not deceive yourself by supposing that they possess any magic powers. The truth about dentifrices is simply that whether you lay them on like a ribbon, dust them on or pour them on, none is more than an aid to the brush in cleaning the teeth, none has therapeutic value of any substantial kind, and none stands out as better than the others to any important degree.—*Reader's Digest*, August, 1943.

Draft Discloses Rate of Syphilis

Congress was recently informed that in the examination of men, aged 21 through 35, for the armed services, 47.7 of each 1,000 were found to have syphilis and that the prevalence among negroes in one Southern State ran to 405.9 in each 1,000.

The figures, which were based on a study of the first 2,000,000 drafted men examined in forty-four States, were given to the House Appropriations Committee by the Public Health Service.

Dr. Thomas Parran, Surgeon-General, said that rejections ran to 46,000 in each 1,000,000 men because of syphilis and 15,000 of each 1,000,000 due to gonorrhea infection. If this ratio held through the examination of 10,000,000 men, there would be more than 610,000 rejections due to venereal diseases.

Venereal Disease Control

The importance of venereal disease control in the war emergency again has been recognized by the Congress by its appropriation for the fifth year of funds to implement the LaFollette-Bulwinkle Venereal Disease Control Act of 1938. As recommended in the President's budget, the sum of $12,500,000 was appropriated for the fiscal year beginning July 1 for the U. S. Public Health Service and for federal aid to the states in the fight against syphilis and gonorrhea. This is the same amount expended for the fiscal year just closed. Progress is thus assured for the coming year. Under the leadership of Surgeon-General Thomas Parran, coöperating with the Army, Navy, Division of Social Protection, and the American Social Hygiene Association, the Service will aid in making new records, it is believed, in "the lowest wartime venereal disease rate in history."

Do Welding Rays Cause Sterility?

There seems to be a fairly widespread rumor that arc welding causes damage to the reproductive organs so that the welder, male or female, is unable to have children.

However, the ultra-violet rays which are given off in arc welding have very little power of penetration. Ordinary clothing absorbs a good part of the rays, and the rest are absorbed in the topmost layers of the skin. None of the rays get through to the vital organs of reproduction.

The welding arc also produces infra-red rays, the kind that are produced by the "baking lamps" in doctors' offices. These rays can penetrate somewhat deeper than the ultra-violet rays of the welding arc, but as everyone knows who has had a baking-lamp treatment, they produce a good deal of heat as well. Before they could cause any real damage to the vital organs, a definite sensation of burning would be noticed and the effect of the burning would be quite uncomfortable.

The only rays which are known to be capable of causing sterility are x-rays. Experiments have been conducted in industrial plants to determine whether x-rays are emitted by the welding arc. Welders carried dental x-ray films in their pockets for weeks at a time to test whether the electric arc produced x-rays, but the results failed to indicate even the slightest amount of x-ray exposure.

Lead Poisoning

It is very unlikely that the welding arc of itself can cause sterility. On the other hand, welders are also subject to metal-fume fever and to lead or manganese poisoning. Lead poisoning is a hazard which occurs when metals covered with lead paint are cut by either the electric arc or the oxyacetylene flame.

The intense heat causes the formation of lead fumes which are capable of producing rapid and severe poisoning of the welder. This has become a real danger in the shipyards, where surfaces already painted with red lead are being welded into place in order to speed up production. Unless proper precautions are taken, cases of serious lead poisoning are likely to result.

Lead poisoning can and does cause damage to the vital sexual tissues, resulting in sterility and miscarriages. Usually, however, lead poisoning causes other symptoms as well, such as fatigue, listlessness, poor appetite, constipation, and abdominal pain.

In summary, it appears to be highly improbable for arc welding rays to damage the reproductive organs. On the other hand, if welding fumes are not properly controlled, it is possible that lead poisoning or metal-fume fever may have a bad effect.

The answer, therefore, lies in the effective control of welding fumes.—San Francisco *People's World*, May 15.

Design for Tomorrow's Maternity Care*

During our 320-odd years of colonial and national life there has never been such need for man or woman power as there is today. The life and well-being of every man, woman, and child suddenly becomes important and we find ourselves ill-prepared and ill-equipped to meet all of the passing needs of medical care. Our first objective in medical care in this country must be to provide effectively and universally for the protection of maternity and the rearing of children who will be healthy in body and mind. We cannot begin too soon to plot out our plan of operation, our campaign for the next ten years.

What is it then that we must do if we are to assure good maternity care to every mother?

First of all, we have to make up our collective minds as to the basic philosophy on which we will proceed. Do we as a nation intend to provide good care for every mother regardless of her place of residence, her race, and her financial status, or are we going to be content with the makeshift plan we have today under which some mothers get the best care that is known anywhere in the world while others get along with no skilled assistance of any sort? When the people understand thoroughly what can and should be done, I do not doubt that they will insist on the first course. Given the will to provide good maternity care to every mother, the ways and means will be found.

What we want for every woman is easily stated: Medical care by a well-trained physician, starting, if possible, before conception or at least not later than the second month of pregnancy and given continuously throughout pregnancy, labor, and the puerperium; medical care for the newborn infant by a physician trained in the care of children; specialized consultant service readily available

* By Dr. Martha M. Eliot, Assistant Chief, U. S. Children's Bureau.

For editorial comment on maternity-pediatric care, see in this issue, on page 105.

as needed by mother or child; nursing care by competent public health and hospital nurses for the mother throughout the whole period of maternity and for the infant; hospital clinic or health center service for the prenatal and postpartum periods for all maternity patients who seek this type of care; delivery care and at least ten days postpartum care in a hospital with all possible safeguards for the health of the mother and newborn infant; facilities for boarding or convalescent care before or after delivery for those mothers whose physical condition or home situation require it; the direct service of trained nurse-midwives working under the direction of a physician to assist with normal cases where there is an inadequate number of physicians to give necessary care; counseling service by a medical social worker in hospital and clinic to assure the provision of adequate food, shelter, clothing, and personal and family adjustment to the condition of maternity.

There would seem to be little reason why decisions should not be reached now as to the general framework and many of the details of a plan for public maternity care and medical care of children to be put into effect after the war. At best it will take ten years to develop the program in all its parts. Today there is enough experience in this country and abroad to warrant laying down basic principles and a pattern of general procedure, but that pattern must be flexible enough to allow for variations in the different States and in urban and rural areas.

A review of this experience leads me to believe that the basic principles upon which we should proceed would be, in general, as follows:

1. Any public program of maternity care and medical care of infants and children should be the joint responsibility of local, State, and Federal governments financed under the grant-in-aid plan from general tax funds;

2. Administrative responsibility should rest with the State departments of health with expenditure of Federal funds under plans approved by the Federal agency given responsibility for the grants;

3. The program should be State-wide in effect and be so organized as to include a network of maternity and pediatric services that will reach out from a few highly organized maternity and pediatric units in hospital and teaching centers to a chain of smaller hospitals and clinics located strategically in medium sized cities and thence to the many small local maternity and child health units in towns and counties and rural areas;

4. Maternity care of good quality should be avaliable under this program to any woman who seeks it regardless of residence, economic status, race, color or creed; eligibility should be on the basis of medical need alone; this is surely one aspect of our total medical care program for which there should be no means test;

5. Standards of care should be established by the responsible administrative agencies with the advice of experts in the various professional and technical fields;

6. Employment practices in the case of professional personnel should be determined, first, by the required standards of care and, second, by economy in the expenditure of public funds;

7. Hospital and clinic facilities meeting established standards of maternity and infant care and care of sick children should be available or easily accessible to every community, rural as well as urban; public institutions should be open to everyone in the community whether the community or the individual pays; existing voluntary, nonprofit institutions, if used, should meet established standards of financial accounting as well as professional service;

8. The plan for training professional and technical personnel should be a part of the plan for service and reach down from the most highly organized teaching unit to the smallest rural unit.—From *Briefs*, Vol. VII, No. 6, June, 1943. Published by the Maternity Center Association, 654 Madison Avenue, New York 21, N. Y.

What an exciting super-tomorrow it will be! Americans are today making the greatest scientific developments in our history. That is a promise of new levels of employment, industrial activity and human happiness.

—Clarence Francis.

COMMITTEE ON MEDICAL ECONOMICS

Fee Schedule of California Industrial Accident Commission

A "proposed" fee schedule for physicians and surgeons to cover services rendered under the Workmen's Compensation and Safety Laws was presented to the Industrial Accident Commission of the State of California by the California Medical Association on December 30, 1942.

The matter is still under consideration by the Commission. A copy of the proposed fee table was sent to all physicians licensed to practice in California. Below are given the covering letters which were mailed with the proposed schedule.

(COPY)

CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, San Francisco

To the Doctors of Medicine of California:

Dear Doctors:

The California Medical Association, representing more than 7,300 Doctors of Medicine in California, has been trying since late last year to have a new fee schedule adopted by the Industrial Accident Commission of the State of California for compensation work.

Enclosed, for your information, is a copy of the fee schedule proposed by the California Medical Association, compared with the fees now in effect with the Industrial Accident Commission. The present fees were approved by the Commission in 1920 and have remained unchanged for more than twenty-three years. As you will readily see, the present fee schedule is not only inadequate but is most incomplete. The proposed fees have been drawn up by a group of qualified physicians as representative of fair and adequate fees for compensation cases.

To date the Industrial Accident Commission has not approved the proposed fee schedule. However, the Commission has indicated that it will give serious consideration to the proposed schedule *if* ways and means can be found to secure the adherence of the physicians of California to the established fee schedule.

In other words, the physicians of California are in a position to secure more adequate fees for compensation work if they themselves will agree to stop the fee-splitting, rebating and discounting of compensation medical and surgical fees which some practitioners are alleged to be carrying on now.

Won't you add your name to the list of physicians who have already agreed to abide by the established fee schedule for compensation? The more agreements of this kind we can get, the better evidence of good faith we will have with the Industrial Accident Commission.

To be included in this form of agreement with all the other Doctors of Medicine of California, just sign the enclosed card and drop it in the mail today. No postage required—just your signature and city. With your help we can all hope for fair and adequate compensation medical and surgical fees.

Fraternally yours,

(Signed) KARL L. SCHAUPP, M. D.
President.

I agree that in compensation cases I will abide strictly by the fee schedule established by the Industrial Accident Commission of the State of California and will adhere to the Principles of Ethics governing compensation practice.

SIGNED.....

CITY.....

Outline of Procedure for Physicians When Claiming Fees Before the Industrial Accident Commission

In any case where a physician is dissatisfied with the fee proposed to be paid by the employer or insurance carrier in any workmen's compensation case, he may file an application with the Industrial Accident Commission for an adjustment of the matter of his fee in the following manner:

1. He should obtain from the Industrial Accident Commission its "Form 34 Revised," entitled "Application for Adjustment of Claim." The Commission has an office in San Francisco in Room 119, State Building, and in Los Angeles in the State Building.

2. The physician should ascertain from the Commission or the injured employee whether the employee has already filed an application with the Commission for an adjustment of his case and, if so, request the file number thereof.

3. The physician should fill in all the information requested on the above-mentioned form. If the employee has already filed his own application, the number of his claim and the title of the claim should be filled in on the form, adding the physician's name as an additional "applicant." If no previous application has been filed by the employee, the physician should fill in his own name as applicant *and also insert the employee's name in the title.* Question 8 on said form should be answered as follows:

"The reasonable value of the medical services rendered to the injured employee by the undersigned applicant physician is the sum of.....Dollars. A detailed statement of the services rendered the employee by the undersigned applicant is attached hereto. The above named employer and employer's insurance carrier have refused to pay compensation for said medical services in said sum (or have refused to pay in excess of..... .....Dollars for said services). The undersigned applicant physician requests the Commission to award the sum of.....Dollars to the employee as the reasonable expense incurred by said employee for medical services and further requests that the applicant physician's claim for medical services rendered, be declared a lien on said sum and that the employer or the insurance carrier be ordered to pay said sum directly to said physician."

The detailed statement of the medical services rendered to the employees should be attached to the application in accordance with the foregoing statement.

4. This application should be filed with the Industrial Accident Commission at either its San Francisco or Los Angeles office within six (6) months after the last treatment by the physician for the injury involved.

Cut in Insurance Rates Is Expected by State Official

State Insurance Commissioner A. Caminetti, Jr., said today reductions averaging 15 to 20 per cent in workmen's compensation insurance rates are expected to result from an investigation by his department into "questionable underwriting practices" in California.

He explained in a report to Governor Earl Warren that the state-wide investigation results from a preliminary probe revealed that special treatment either was obtained or given to employers through improper classification of risks, inaccurate reporting and auditing of pay rolls and various other devices.

Thorough Probe Agreed On

"Since any widespread practice along these lines must have the effect of distorting the data on the basis of which rates are fixed and premiums collected," he said, "it was deemed essential that a thorough investigation be made. When the existing condition is cleaned up, it should result in an average reduction of from 15 to 20 per cent in rates."

The investigation so far, he declared, has disclosed "an alarming prevalence" of discriminating practices and violation of the laws with respect to the giving of rebates. Some of the methods employed, he said, were so transparent they can be described only as wilful violations.

Evasion Methods Listed

He listed as some of the most common means employed in the evasion of proper ratings:

1. Concealment of pay rolls.
2. Misclassification of risks.
3. Acceptance by compensation insurance carriers of the assured's pay-roll statements without verification.
4. Agreements to write compensation in conjunction with other lines of insurance not subject to minimum rating laws.
5. Substitution of fictitious loss reports for reports of actual loss.
6. *Discounting physicians' bills while nevertheless reporting the gross amount for rating and experience purposes.*

Extent Undetermined

"The extent of the inaccuracies and misclassifications presently existing cannot at this stage be accurately gauged," Caminetti said, "but it is significant that in 132 audits completed involving pay rolls reported at $66,500,000, additional unreported pay rolls of $3,200,000 were disclosed. The investigation audits developed required premiums of $1,908,000 as against $1,551,000 reported."

It is to be hoped, he added, that the investigation may result in an eradication of "these destructive practices" and the laying of a sure foundation for rate making in workmen's compensation insurance.—Sacramento *Bee*, June 30.

Insurance Indemnification

The following letter was recently sent to the component county societies of the California Medical Association:

(COPY)

June 24, 1943.

Dear Doctors:

In the past few years the California Medical Association office has received an increasing number of inquiries from physicians as to the best method of handling their fees in cases where the patient carries indemnification insurance but where the indemnification might not represent the full fee which the physician believes to be proper.

For instance, a patient may have an indemnification insurance policy which allows him $50 for a hernia operation. The physician's fee might be set at $100, but the patient hopes to be relieved of any additional payment. The insurance carrier, upon receipt of proof of the surgery, may send to the physician its check for $50, the check being imprinted with some such statement as "In full payment for professional services rendered to John Doe."

If the physician accepts this check as part payment of his full fee, he is defeating his case for collection of the full fee. The physician has no contractual or other relationship with the indemnity insurance company. Such company's contract is with the patient.

The California Medical Association Council at its meeting of June 19 to 20, 1943, voted to forward to its members, through their county societies, the following instructions in such cases:

Do not accept checks from insurance companies for fees of patients carrying medical or surgical indemnification policies. You are under no contractual obligations to the insurance carrier, but are dealing directly and only with the patient under the usual physician-patient relationship.

Return such checks to the insurance company, together with a simple statement to the effect that you are handling

the matter of your fee direct with the patient. If the insurance company wishes to send its indemnification check to the patient, that is a matter between the company and its policyholder.

Please bear in mind that these instructions apply only in cases of commercial insurance companies, employee benefit organizations, etc. *They are not applicable in the case of patients under California Physicians' Service memberships or in the case of patients covered by compensation insurance.*

The strict adherence of your members to these instructions will help greatly in combating the tendency of many commercial insurance companies to establish a schedule of medical and surgical fees which is too low and in no way representative of the fair value of the services.

Please give these instructions the widest possible publicity among your members.

Fraternally yours,

PHILIP K. GILMAN,
Chairman of the Council.

Prepaid Medical Plan Under Doctors' Study

A new medical organization to develop prepaid, group medical care throughout the nation met in Chicago on June 6 with the American Medical Association.

The group is the Medical Service Plans Council of America, organized four months ago, with 129 nonprofit, prepayment plans in actual operation in thirty-five states and Canada, covering about 13,000,000 persons.

Dr. James C. McCann, Worcester, Massachusetts, is president of the new council, and Dr. Frank L. Feierabend, Kansas City, is secretary-treasurer.

There are two classes of prepayment groups. Seventy-seven are group hospital associations and fifty-two are limited to surgery, births, and catastrophes like major accidents. Only these two classes, both of limited service, have succeeded well. Complete prepaid medical care is also being tried, but in the main costs too much.

The trustees of the American Medical Association summarized the difficulties in a report to guide physicians.

It said that the original complete medical service plans are being changed to limited surgical and obstetric care for hospitalized patients.

"It early became evident," said this report, "that an unlimited medical care plan involved a greater expense than can be met by any premiums the public is at present willing to pay."

Further, the report declared that the public "has been deceived as to cost by the propaganda for compulsory sickness insurance and for lay-administered plans."

The trustees' report sets up the principles that the medical care plans must never deceive the public, that there must be free choice of doctors, and no change in the personal relation between doctor and patient.—Los Angeles *Times*, June 7.

A "New Order" for the United States?

GOP Governor: "The Washington Mighty Want It"

Governor Edward Martin of Pennsylvania . . . in an address prepared for Flag day exercises in Independence Hall, declared that the report of the National Resources Planning Board is "the Holy Book of the new American order," and said it proposes "the system whereby our economic Fascists hope to control every step taken by Americans from their cradles to their graves."

Describing the Planning Board report, which proposed a social insurance to assure all Americans of lifelong freedom from want, Martin said:

"Its purpose is to end the incentive system and discourage or destroy the American initiative that . . . made this the freest and strongest nation in the world.

"It promises to set up a caste and class system whereby the young men and women of America will be frozen into a politico-economic system. It will sound the death knell to ambition.

"This great conflict of ideas is world-wide and is being fought in America under the smoke screen of war."—San Francisco *Chronicle*, June 15.

From Washington: Postwar Problems in Medical Service

Scores of doctors have asked Washington for enlightenment concerning the growing prospect they may be kept in uniform for years to staff veterans' hospitals. Officials cannot vouchsafe details on the postwar program but it is evident many medicos must be held over.

An eventual army-navy establishment of 10,000,000 men, possibly more, will mean heavy casualties from battle, disease and exposure. If the disabled total only 5 per cent —a conservative estimate—there will be 500,000 patients requiring attention, of whom large numbers will be chronic cases. Present plans contemplate an enormous extension of the physical plant, necessitating a tremendous personnel.

It is probable physicians will be asked to remain "voluntarily," but if the response does not produce an adequate force they will be obliged to forego a return to private practice.

Their possible retention in the armed services raises immediate personal problems. Many have invested thousands of dollars in office equipment which may deteriorate or become obsolete before the date of discharge. They must decide whether they should dispose of apparatus now or continue to pay insurance and storage costs.

A shortage of doctors for civilians after the peace may lead to a nationwide, federally operated medical service with wartime units as a center.—Sacramento *Bee*, June 10.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Doctor Shortage in East Bay Hospitals: San Francisco Bay Area

(Copy of Joint Report to Alameda County Medical Association and East Bay Hospital Conference.)

Four meetings have been held of the Liaison Committee, composed of representatives of the Alameda County Medical Association and representatives of the East Bay Hospital Conference, to discuss the shortage of hospital beds for private patients in the East Bay area.

The Alameda County Medical Association was represented by Dr. Clarence A. DePuy (chairman), Dr. R. T. Sutherland, and Dr. S. A. Jelte. The East Bay Hospital Conference was represented by Alfred E. Maffly of Berkeley Hospital (chairman), J. S. Rafter of Richmond Hospital, and Miss Ruth Wescott of Alameda Hospital. Others invited to attend the meetings were: Dr. Clifford Mack, president of the Alameda County Medical Association; G. U. Wood of Peralta Hospital, Miss Rainbow of the Visiting Nurse Association, Keith Taylor of Children's Hospital, and Doctor Blankenship of the U. S. Public Health Service.

Discussion

The main topic of the discussions was the shortage of hospital beds in the East Bay area. The medical profession and the hospitals of this area are both severely criticized by the public every time a patient is denied hospital facilities. For each patient rejected there is increasing pressure placed upon the Alameda County Hospital to open up its one hundred additional beds, and the Kaiser Group is further fortified in its demands for additional hospital facilities for 266 more bed patients. Neither physicians nor

hospitals desire to see pay hospital patients accepted by the County Hospital nor further expansion of the corporate practice of medicine.

Discussion revealed that patients were being rejected by East Bay hospitals, not merely because of shortage of hospital beds and hospital facilities, but primarily because of the shortage of nurses and trained hospital personnel. Most of the hospitals have been increasing their capacities by purchasing additional beds and additional bedside equipment and doubling up their present facilities. There has been no particular difficulty experienced in purchasing hospital equipment of this type. The main problem has constantly been the increasing shortage of hospital man power. Hospitals have frequently been obliged to cancel surgery and to reject bed patients, even though they had unfilled beds available, because of inadequate nursing care for the facilities which they did have. Purchase of additional beds alone will solve little.

Spot Check on Hospital Facilities

The Committee made several spot checks of hospital facilities and hospital occupancy. The following is a typical study taken of the nine approved hospitals at midnight on May 10, 1943. The census figures were taken at midnight, as this is the usual customary time of computation.

OCCUPANCY STATISTICS

Approved Private Hospitals in East Bay May 29, 1943

11:59 p. m. (Midnight)

Hospital	Total Capacity	Empty Adult Beds	Rejected Patients 5/21-5/27	Per Cent Occupancy
Alameda	97	21	8	
Alta Bates	116	14	0	
Berkeley	90	23	0	
Children's	70	12	0	
East Oakland	80	12	1	
			(No pvt. rm.)	
Merritt	178	11	42	
Peralta	160	14	12	
Providence	220	28	6	
Richmond	61	9	0	
	1,072	144	69	77

Of 1,072 hospital beds now available for private patients (not including bassinets for newborn), 144 were empty at midnight of May 29. However, while it was true that many of these empty beds were filled the following noon and certain hospitals were completely filled to capacity by then, other hospitals were not overloaded and could have taken care of patients rejected.

Under present conditions several hospitals are reserving their beds primarily for the use of their active staff. In fact, some of the hospitals have made their beds available to their active staff *exclusively*, even though there were empty beds which might have been used by courtesy staff members.

Conclusions and Recommendations

The Committee wishes to express the following conclusions and recommendations:

1. *There is no overwhelming shortage of hospital facilities in the East Bay.* Present facilities are cramped and are being used to capacity, but should be adequate to take care of the acutely ill and severely injured. If our hospital facilities are used to maximum capacity, all luxury hospitalization abolished, all patients discharged from the hospital at the earliest possible time, and with complete coöperation of the doctors and hospitals, it should rarely be necessary to reject critically ill private patients.

2. *Further reduction in the average hospital stay of patients.* Obstetrical cases have already been reduced from ten days to five days in most hospitals. Surgical and medical patient stays should similarly be reduced to 50 per cent if possible. The hospital stay of industrial cases should be greatly reduced.

3. *Orthopedic and other convalescent patients* should be sent home or transferred to convalescent homes as quickly as possible. A list of convalescent homes should be prepared for the Central Clearing Agency.

4. *Facilities for the rental of bedside equipment* should be investigated so that more hospital facilities might be made available to encourage some of the less acutely ill patients to set up their own hospital facilities at home.

5. Arrangements might be made with the *Visiting Nurse Association* for more bedside care at home.

6. *Luxury nursing and luxury hospital service should be abolished for the duration.* Hospital and nursing care should be requested on the basis of medical need only, not merely because of the financial ability to pay.

7. *Special duty nursing should be minimized* to assure more efficient distribution of the available nursing care. Special nursing should be limited to the extremely sick and for medical reasons only. Special nurses should care for two or three or even four patients at one time.

8. *Registered nurses* now employed in doctors' offices should be encouraged to accept general staff duty, and doctors encouraged to employ competent medical secretaries rather than registered nurses wherever possible.

9. *Retired and inactive nurses* should be encouraged to enroll in refresher courses and return to the field of general duty nursing either on a full time or a part time basis as part of the Victory Nurse Program.

10. *Hospitals should make full use of volunteers. Red Cross nurses aides* should be used more extensively in hospitals to relieve nurses. Doctor Sutherland investigated the availability of volunteer help for the Committee and found that hospitals had not used volunteers to maximum capacity in their various departments. By July 31, 1943, 743 nurses' aides will have been graduated by the Red Cross in Oakland and Berkeley. Each hospital should set up a weekly program stating the number of aides desired, preferably by regular four-hour periods each week. The Red Cross already has many more nurses' aides available than the hospitals have been willing to absorb. When sent to the hospital, the aides should be used for real work and not just tolerated.

11. Hospitals should take advantage of *Victory Worker Campaigns* being conducted by local manpower committees. Many victory workers are available for work in hospital and other essential industries after they have completed their regular day's work of eight hours in other occupations. Victory workers are available for four-hour or other part-time shifts. Many housewives are available for such part-time work in hospitals after completing their home tasks each day.

12. *Hospital staffs should not hoard beds for their active staff members.* Empty beds should be made available to all members of the Alameda County Medical Association for the duration. Doctors should become active staff members in more than one hospital so that they will have more hospital beds available for their practice.

13. *If the present pressure for hospital facilities becomes more acute, it is recommended that a central clearing agency might be set up for more effectual use of vacant beds.* The Alameda County Medical Association or the East Bay Hospital Conference could maintain such a clearing house in their secretaries' office. One clerk could be detailed to telephone each of the nine hospitals every morning to determine the number of empty beds available. When a physician could not be accommodated by the hospital of which he is an active staff member, he could be aided by the central clearing agency, which might be able to assist him to procure accommodations in another hospital which happened to have vacant beds at that time. This plan would require the coöperation of all hospital staffs and their willingness to make their empty beds available to all members of the Alameda County Medical Association.

In Conclusion

In conclusion, your Committee is convinced that present hospital facilities in this area should be adequate to take care of those urgently needing hospital care, provided doctor, hospital, and patients are willing to coöperate for the duration in eliminating luxury services, and willing to ration hospital facilities for the benefit of the severely ill in the most efficient manner.

June 15, 1943.

Respectfully submitted,

CLARENCE A. DEPUY, M.D.,
Medical Chairman.

ALFRED E. MAFFLY,
Hospital Chairman.

Medical Staffs Give $101,250 to Hospital Fund

Medical staffs of eight Los Angeles nonprofit hospitals—the doctors who best know the immediate need for 800 beds and other facilities—have contributed $101,250 to the United Hospital Fund $3,000,000 campaign.

Dr. L. A. Alesen, secretary of the Los Angeles County Medical Association, announced the staff gifts yesterday.

Physicians and surgeons are giving generously, Doctor Alesen said, because they know the danger confronting the public when hospitals are unable to care for all the patients.

"They realize that an average of more than one thousand persons a month are being turned away by these hospitals," he explained, "while many hundreds of patients are discharged earlier than is desirable in order to make room for new patients."—Los Angeles *Times*, July 14.

County Auditor Hits Hospitals' Billing Method

The method known as "selective billing" of patients treated at the Los Angeles County General Hospital and kindred institutions operated by the county government was criticized in a report by County Auditor J. M. Lowery to the Board of Supervisors.

Selective billing permits segregation of patients, those who might pay for their hospitalization from those unlikely to pay.

According to the Auditor the county is losing revenue because of the selective billing system and he recommended that it be discontinued for the General Hospital. . . .

Arthur J. Will, Director of County Institutions, in a communication to the Board, favors the selective billing system. He says:

"To review periodically all past cases of General Hospital patients and seek reimbursement from all who have not paid would require a staff of five hundred persons.—Los Angeles *Times*, June 14.

"Twenty-Five Years Ago"—The Way Things Change

The following news item refers to comment which appeared in the "Twenty-Five Years Ago" department of CALIFORNIA AND WESTERN MEDICINE:

CALIFORNIA AND WESTERN MEDICINE, the official journal of the California Medical Association, has a feature called "Twenty-Five Years Ago," in which are reproduced interesting items which appeared in the magazine a quarter of a century ago. In a recent issue of the magazine, one of the items reprinted concerned the Navy's call for binoculars, spyglasses and telescopes in 1918. The writer of the story stated that an appeal in the daily press had resulted in the receipt of more than 3,000 glasses. "This number, however," he said, "is wholly insufficient, and the Navy needs many thousands more." And we add his next paragraph in full, just to show you what some people were occupied with a quarter of a century ago. "All articles should be securely tagged, giving the name and address of the donor, and forwarded by mail or express to the Honorable Franklin D. Roosevelt, Assistant Secretary of the Navy, care of Naval Observatory, Washington, D. C., so that they may be acknowledged by him."—San Francisco *Chronicle*, June 2.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (44)

Alameda County (2)
Barron, Gilbert, *Oakland*
Ellis, John Malcolm, *Berkeley*

Fresno County (1)
Hagen, Kathryn L., *Fresno*

Imperial County (2)
Gregory, Benjamin F., *Brawley*
Yellen, Benjamin L., *Brawley*

Kern County (2)
Seibly, John, *Bakersfield*
Wynia, Frederick, *Bakersfield*

Los Angeles County (18)
Borsook, M. E., *Los Angeles*
Chaney, O. J., *Inglewood*
Cummings, Arthur L., *Burbank*
Eames, Earl, *Roscoe*
Freed, Arnold Lawrence, *Los Angeles*
Jameson, Moroni, *Long Beach*
Jones, Wilfred M. G., *Los Angeles*
Kelly, Edward H., *Monrovia*
Knouf, Evelynne G., *San Marino*
Lee, Harold I., *Duarte*
Lynn, Isaac W., *Burbank*
Naiditch, Morris J., *Los Angeles*
Neufeld, Otto J., *Los Angeles*
Potter, Glenn James, *Los Angeles*
Shayne, David M., *Los Angeles*
Stewart, Robert B., *Los Angeles*
Stricker, Robert L., *Los Angeles*
Woodruff, James Lloyd, *Los Angeles*

Monterey County (1)
Whiffen, Robert A., *Salinas*

Orange County (4)
Anderson, Ralph D., *Orange*
Artress, F. Lynn, *Fullerton*
Koch, George W., *Anaheim*
Schroeder, Alfred L., *Orange*

Riverside County (1)
O'Connell, Raymond, *Indio*

Sacramento County (2)
Bockrath, Henry M., *Sacramento*
Ogaard, Adolph T., *New Orleans, Louisiana*

San Diego County (1)
Oliphant, Charles L., *Topeka, Kansas*

San Luis Obispo County (1)
Pearman, Robert O., *San Luis Obispo*

Santa Barbara County (1)
Dixon, J. Lowell, *Santa Barbara*

Santa Clara County (4)
Brundage, Burchard M., *San Jose*
Hardenbergh, Helen, *San Jose*
Robertson, Gaynelle, *Palo Alto*
Watson, Robert W., *San Jose*

Santa Cruz County (1)
Holleman, Clarence H., *Santa Cruz*

Stanislaus County (2)
Semmens, D. W., *Modesto*
Treadwell, Richard R., *Modesto*

Yuba-Sutter-Colusa County (1)
Clemens, H. H., *Morganville*

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

Transfers (3)

Frank, Justin A., from Santa Barbara County to Los Angeles County

Obrien, George F., from Solano County to Sacramento County

Wood, Howard Asa, from Riverside County to Los Angeles County

Retired Members (1)

Coffey, Walter B., *San Francisco*

In Memoriam

Altman, Allen Ashton. (Lieutenant, MC, USA). Died at Adak, Alaska, April 11, 1943, age 29. Graduate of Stanford University School of Medicine, 1939. Licensed in California in 1939. Doctor Altman was a member of the San Francisco County Medical Society and the California Medical Association.

✝

Augspurger, Elmer David. Died at San Francisco, June 25, 1943, age 63. Graduate of the University of Illinois College of Medicine, Chicago, 1907. Licensed in California in 1915. Doctor Augspurger was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Beach, Everett Charles. Died at Oxnard, July 8, 1943, age 63. Graduate of the Baltimore Medical College, Maryland, 1907. Licensed in California in 1908. Doctor Beach was a member of the Ventura County Medical Society and the California Medical Association.

✝

McManus, Edward Austin. Died at Los Angeles, June 9, 1943, age 53. Graduate of the Royal College of Physicians of Ireland, 1923. Licensed in California in 1938. Doctor McManus was a member of the Los Angeles County Medical Association and the California Medical Association.

✝

Rapaport, Hyman. Died at Los Angeles, June 16, 1943, age 51. Graduate of the University of Pittsburgh School of Medicine, Pennsylvania, 1919. Licensed in California in 1920. Doctor Rapaport was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Walker, Clifford Black. Died at Los Angeles, July 3, 1943, age 58. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1911. Licensed in California in 1924. Doctor Walker was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Wolfsohn, Julian Mast. Died at San Francisco, July 1, 1943, age 60. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1911. Licensed in California in 1911. Doctor Wolfsohn was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Zeiler, Avrum Herman. Died at Los Angeles, July 16, 1943, age 61. Graduate of Columbia University College of Physicians and Surgeons, New York City, 1905. Licensed in California in 1912. Doctor Zeiler was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

OBITUARIES

A. H. Zeiler
1882–1943

We have lost a friend, and such a friend! Herman Zeiler was the doctor's doctor, ready day or night, though sometimes sick himself, to lend aid whenever a colleague asked assistance. And the calls were frequent, for Zeiler participated in the inauguration of clinical laboratories at six Los Angeles hospitals and supervised the work of a capable staff. Besides institutional commitments, he shared heavily the responsibility in a group conducting an active private laboratory that served physicians individually. In this capacity, alert to the steady progress of medical science, he was able to shorten the lag between the publication of significant discoveries and their wide application to the practice of medicine. He earned the gratitude of fellow physicians, along with the manifold blessings of their patients.

Born in Sombor, Austria (Hungary), Herman came with his parents to America when five years old. The family settled in Leadville, Colorado. His medical education began at the College of Physicians and Surgeons, New York, affiliated with Columbia University. He was graduated in 1905. His training was continued at Bellevue Hospital, at municipal institutions on Blackwell's Island, and culminated while in the service of his country under the command of General Gorgas in the Panama Canal Zone.

In other ways, pivotal indeed, residence in the tropics was kindly and brought fair rewards. There he met Miss Geneva Dunkl, whom later he married. Two children were born to them, a son and a daughter. Also, he became acquainted there with Dr. Walter Brem and a relationship began which flourished, inspiring them to move to Los Angeles in 1911 with a plan for establishing jointly a pathological laboratory comparable with those in the Government hospitals at Ancon and Colon, where they had worked side by side.

The venture at first had limited objectives, aspiring chiefly to interpret the lesions in tissues removed at operation, thus to guide the subsequent welfare of the patient.

Pertinent, of course, was the blood picture before and after operation. Again, in other instances, medical cases, repeated differential counts were required to learn the effect of treatment upon profound anemia or leukemia. These events merit emphasis because they pointed the notable expansion about to occur in the laboratory and give it prominence for pioneering blood transfusions as well as intravenous therapy of different kinds. Step by step, equipment was acquired for microchemical study of the blood, intricate procedures of urinalysis, refined bacteriological technique, metabolic research, and various innovations in the field of pathological physiology during the past three decades. Enumeration of these details is more convincing than mere statement of the fact that Zeiler had an open mind, quick to avail himself of the truths science discloses for the benefit of sick men and women.

For him Medicine was both vocation and avocation. Leisure was found to contribute toward the activities of the County Medical Association: Membership on committees, the furtherance of lay knowledge relative to the rôle of doctors in the solution of community problems, the advancement of the peculiar interests of the Society, scientific and financial. In this regard one illustration is afforded by the energy he expended in bringing to accomplishment the project of the Wilshire Medical Building, which through the lease of land by the Association supplies resources to multiply our library facilities and makes the future of the Association exceptionally secure.

Personal appreciation of Herman Zeiler by his colleagues was always prompt and genuine. Honest to the core and with no veneer to obscure the man's straightforward purpose, work was the pith of his philosophy. Never did he spare himself, despite intermittent attacks of illness covering nearly a score of years. Persistently outgiving, faithful to any responsibility he assumed, critical of himself but not of his associates, modest, understanding, upright, loyal—he made a host of friends and kept them.

A Tribute From an Old Friend.

✠

Clifford B. Walker
1884–1943

The world of science lost one of its most brilliant and shining stars when Dr. Clifford B. Walker of Los Angeles died on July 3, 1943. Doctor Walker was born in Vermont, acquired part of his education in Pasadena, received his B. S. in 1906 from the University of California, and was graduated from Johns Hopkins Medical School in 1911, already with a proved talent for research. In 1913, at the opening of the Peter Bent Brigham Hospital in Boston, he was selected as one of that remarkable group of young men of genius and talent which Dr. Harvey Cushing gathered about him, dedicated to the study of the nervous system as a surgical field of promise and hope.

Doctor Walker was not only a man of talent, but definitely in the genius class. His special bent for physics and mathematics made it natural for him to do his research in the abstruse realms of optics and the physics and physiology of the eye.

It was this genius, plus unrelenting study and intensive research, which blossomed into the many contributions he gave to the world, such as his operative procedure for detachment of the retina, and the "Walker" screen for visual fields. Doctor Walker's knowledge of quantitative perimetry became so outstanding that it received merited recognition throughout the scientific world, a recognition signalized by the award to him of the rare and coveted Knapp Memorial Prize, given only for the highest achievements in ophthalmology.

Doctor Walker was a man of great talents, a physician who did much pioneer work in a difficult field of science. It will not be an easy task to find his equal.

George P. Laton, M. D.

✠

Dorsey A. Harwood
1879–1943

This is a tribute to the memory of a fine, courtly gentleman; to a man whose cultural and professional attainments placed him upon a conspicuous pedestal of professional esteem and popularity in Santa Ana, in Orange County, and throughout the State of California.

Dorsey A. Harwood was born in Manville, Illinois, on December 5, 1879. He chose the profession of medicine as his life's vocation and was graduated from the University of Illinois in 1906. He served his interneship in St. Luke's Hospital and practiced at Ransom and Streator in Illinois until 1920, when he made his way to California and settled in Santa Ana. There he acquired a well-deserved and enviable reputation as a surgeon, paying particular attention to malignant diseases.

To all appearances, Doctor Harwood enjoyed excellent health, but he, himself, was aware of a serious heart condition. Nevertheless, he continued to work until within two days of his untimely death.

Doctor Harwood was a representative of a rare type: sound in logic, keen in judgment, strong in his convictions and often apparently abrupt, yet kindly and lovable.

Doctor Harwood's death is a severe loss to the Orange County Medical Society, of which he was president for the current year. This is a brief and inadequate summary of the life of a man who was a credit and an honor to the medical profession, and whose days were filled with kind deeds and splendid achievements. C. C. V.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. CHARLES C. LANDIS.....President
MRS. ROGER McKENZIE.....Chairman of Publicity

Pending readjustment in the duties of officers of the California Medical Association Woman's Auxiliary, space allotted to this department is allocated this month to a report on the Cancer Control Educational Program of the Women's Field Army of the "American Society for the Control of Cancer." Report follows.

The Cancer Control Educational Program for 1943. At this time we purposely leave the clinical or medical phase of the educational work to the trained physician, where it rightfully belongs.

The educational progress in cancer control is basically one of personal contact and personal participation.

Clarence Cook Little, D. Sc., managing director of the American Society for the Control of Cancer, Inc., announces in making an analytic study looking toward a secondary school cancer-control study program: "It is increasingly clear that the time is ripe for an intensive drive to bring the secondary schools into our program. The ad-

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Roger McKenzie, 138 Twenty-fifth Avenue, San Francisco. For roster of state and county officers, see page 6, in front advertising section.

vantage of such participation by young people is evident. If they are trained to be interested and active in cancer control before cancer becomes a personal problem, their attitude as adults will be more rational, more constructive, and less one of uncontrolled emotion."

We have undertaken in California this year a vigorous expansion of the educational program to try to reach the young adult public. We have contacted each of the 450 high schools in the State and suggested that through the science, biology, or health courses that accurate general information be obtained from representatives of the American Society for the Control of Cancer in their community and that this material be used in classroom discussion. There are many easily understood pamphlets carefully written for the public that high school students can understand. There are two excellent sound films, entitled "Choose to Live" and "Enemy X," which will be shown in many general assemblies throughout the State.

A 500-word essay contest is being sponsored among California high school students on the subject, "Fight Cancer With Knowledge." An award of a $25 war bond is being offered for the best essay submitted, governed by the decision of three judges.

Over one hundred junior colleges, colleges, and universities in California are being stimulated as to obtain scientific material in the form of pamphlets, books, and films. It is extremely important that every young adult be made aware of the nature of the disease, its first signs and symptoms, and the availability of reliable diagnosis and treatment.

Also, this year, the State Committee has prepared and issued a brief outline of instructions, in response to requests from the Red Cross chapters, on the care of cancer patients to be included in lectures to Volunteer Nurses' Aide Corps and Home Nursing Classes as a special part of the war-time service educational program. . . .

Knowledge is the one weapon with which we can fight cancer and expect to win. There is no need to withhold information about cancer, as it has been proved time and time again that accurate information in the minds of young and old alike gives rise to intelligent questions and understanding of the problems involved and destroys fear rather than creates it. Mysterious half-truths and exaggerated accounts give birth to misapprehension and false notions which do not help in conquering any major enemy.

We have emphasized the cancer control educational program and indicated to you the methods used. Through lectures, radio programs, literature, sound films, magazine and newspaper articles and editorials, and the 500-word essay contest in the high schools, we hope to bring into every home, scientific information that will unfold already proved knowledge available to every citizen. . . .

In the United States there are more than 376 clinics approved of by the American College of Surgeons, and in the State of California there are twenty-two approved clinics. Cancer preventive clinics have been established in many communities throughout the nation.

Let us all be as informed as the group of California high school students and vigorously carry out on the home front, with knowledge as our weapon, a fight against an enemy we can conquer.

Avail yourselves of pamphlets and other material being distributed by the California State Division of the Women's Field Army of the American Society for the Control of Cancer, Inc., from the State office, 3 West Carrillo Street, Santa Barbara, or your county division.

HELEN INGALLS ULLMAN,
State Commander.

DR. HELEN E. SWEET,
Educational Director.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (June, 1943)		46,350
Rural Health Program		5,000
War Housing Projects (approximate)		41,759
Marin	6,308	
Los Angeles	6,581	
San Diego	13,320	
Vallejo	14,750	
San Francisco	1,747	
Total		93,309

There has been a great deal of discussion lately about California Physicians' Service activities in collaboration with governmental agencies. A goodly segment of the medical profession has intimated that this is a very dangerous practice in that it is leading the medical profession into the hands of these agencies. Some of these persons also believe that California Physicians' Service, because of these activities, is leading the medical profession into state medicine. Some of the rumblings of the medical profession, which were evident at the recent meeting of the Medical Association at Los Angeles, and more recently at the special meeting of the Council of the California Medical Association to discuss California Physicians' Service activities, lead us to believe that this is one of the fundamental misconceptions on the part of those who have objections to California Physicians' Service. For this reason, it may be well for us to review some of the relationships the California Physicians' Service has had with the two governmental agencies with which they are now collaborating, namely, the Farm Security Administration and the Federal Public Housing Authority.

* * *

The *Farm Security Administration* was one of the first governmental agencies to enter the field of medical care on a large-scale basis. Today their program has developed to a point where it is probably the largest single medical care program in the United States. It is operating in practically every state in the Union. The policy of the Farm Security Administration has always been, before introducing its plan in any state, to first clear with the Medical Association of that state. After having obtained their endorsement, the Farm Security Administration then went out to deal with local county medical societies in areas where their program was to be put into effect. This has been the story of the Farm Security, and it has several thousand so-called "county units" now operating.

The Farm Security Administration was very anxious to come into California about the time that California Physicians' Service was organized. After the California Physicians' Service machinery was developed, the Farm Security Administration, which has quite a sizeable rehabilitation plan here, came to the California Medical Association with a proposal to introduce its program. It was only natural at that time that the matter be referred to California Physicians' Service. We entered into an experimental program with them in three areas in this State on a basis quite different from any other program they had operating in any other part of the nation. Whereas most other pro-

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

grams were very limited in nature and cost between $18 and $25 a year, California Physicians' Service was able to negotiate a contract with the Farm Security for more extensive service at a considerably increased rate—that is, approximately $50.

Because the experiment worked out quite successfully the first year, the Farm Security Administration desired to spread the program on a state-wide basis, and did so. As the program spread, it was evident to California Physicians' Service that a wide, diffuse program was a different venture than three small concentrated programs, and contained a good many administrative difficulties not common to the experience we had gone through in the previous year.

For this reason, the second year did not work out quite as well as the first and before going into the third year California Physicians' Service was able to sit down with the Farm Security Administration officials and renegotiate the contract on the basis of the experience so gathered. The contract that will go into effect at the end of this year is a clean-cut one; it has a lot of the objections to it removed, and is undoubtedly financially sound.

We mention this fact because it can be seen from here that a governmental agency is able to sit down with representatives of the medical profession and to discuss problems and to solve them by mutual agreement. It also shows the very desirable feature that the program is flexible and can be changed from time to time as all of us get more experience in unknown fields. The Government must necessarily enter this picture, because these farmers are the so-called "low income" farmers, and are borrowers from the Farm Security Administration, and in many cases are even given grants for medical care by that agency. The part played by the Government in the picture, then, is to arrange for the finances and to arrange for the enrollment of the prospective members. This reduces considerably the cost to the medical profession in reaching the group of people we are most anxious to care for.

* * *

This same type of arrangement has been used in relation to the *Federal Public Housing Authority*, wherein the medical needs of the disaster areas connected with war production had to be met. The procedure followed with the Farm Security Administration was followed in our negotiations with the Housing Authority. This program has been in effect only six months, and our figures have already shown that there are inherent weaknesses in the plan and that they must be rectified quickly.

Despite all the consulting with every known expert on the subject of medical care, the actuarial standing of the plan completely overrode any predictions. It is to be remembered that in arranging this plan we consulted with experts of the United States Public Health Service, whose job it has been for years to study the costs of medical care. This is the type of information that governmental agencies have been gathering in anticipation of the possibility of some national action. These figures are the ones that will be used in the compiling of any medical care of public nature.

Because we are dealing with a governmental agency on a contractual basis, California Physicians' Service, finding itself not discharging its responsibility to the medical profession as a whole in relation to fees for services, found it necessary to notify the Housing Authority that the contract would be terminated in sixty days unless certain readjustments could be made. These negotiations are under way at the present time—this time using the figures that California Physicians' Service has accumulated in actual experience while rendering care. Undoubtedly readjustments will be made in the form of reducing some of the benefits or increasing the cost. This flexibility is in startling contrast to fees that are fixed by legislation. We only have to mention the inflexibility of the Industrial Accident schedule.

In all of these negotiations the Housing Authority has shown great willingness to deal with California Physicians' Service, and is extremely interested in the experience that we have had. This is not only true of this agency as well as the Farm Security Administration, but all other parties who are interested in medical care. In all of our dealings with governmental agencies there has been a clear dividing line between the functions of the Government and the functions of the medical plan. The administration of the professional matters, relationship of doctors, hospitals, etc., has been completely in the hands of California Physicians' Service. There has never been at any time any interference on professional matters by the governmental agencies. They are only too glad to have this responsibility placed in the hands of those in whom they have confidence.

This is the first time in the history of the United States that information on a practical basis, rather than a theoretical basis, is being obtained. It is not unimaginable that this information will not be confined locally, but will gradually come to the hands of those who are really trying to find out costs, and the various problems that must be faced in instituting a widespread medical care program.

There is complete evidence, then, in the experience of California Physicians' Service in dealing with governmental agencies, that there is no intent on their part to interfere; as a matter of fact, there is a desire on their part to have the medical profession coöperate with them in endeavors in which they find medical care a necessary part of their programs. The only State in the Union where they can approach this subject on a state-wide basis is California.

* * *

(COPY)

(Copy of California Physicians' Service Report of July 22 to Professional Members)

CALIFORNIA PHYSICIANS' SERVICE
153 Kearny Street
San Francisco, California
743 South Grand View Street
Los Angeles, California

All of us realize that the key to successful operations is the coöperation of the medical profession. One of our problems has been the development of a method by which the medical profession can adequately be informed as to the various California Physicians' Service functions.

Our enrollment of beneficiary members has been mostly in the San Francisco and Los Angeles areas. During the past four years we have had numerous inquiries from county medical societies and from employed groups within these counties asking that our service be inaugurated. We have now developed a method of operation by counties which is in accord with the wishes of the county medical societies and the public. We are organizing these districts in the following manner:

Upon the approval and under the sponsorship of the county medical society, California Physicians' Service sets up a district office and places a district manager in charge. The only program presented to the employed groups whose family income is $3,000 a year or less is "Surgical and Hospital Care." Each doctor is contacted, the plan is thoroughly explained and his approval secured. The district manager reports his activities to the county medical society each month. Any differences or complaints from doctors or groups is given immediate attention by the district manager. Recommendations and suggestions from the county medical society are transmitted to the trustees of California Physicians' Service. This "district plan" is now operating in several counties, and to date the results have been most gratifying because this method tends to:

1. Keep the county societies informed as to our local as well as state-wide operations.

2. Afford county societies an organized means of expression regarding California Physicians' Service.

3. Advise the public that their local doctors are willing to help solve their medical problems.

Financial operations for the month of May are as follows:

Membership dues	$54,591.15
Professional member registration fee	45.00
	54,636.15
Administrative costs	10,420.12
	44,216.03
Hospital and laboratory	2,049.95
Available for medical service	42,166.08
20,730.8 units of service at $1.75	36,278.90
Transferred to Unit Stabilization Fund	5,887.18
Previous balance in Fund	30,507.13
Present balance in Unit Stabilization Fund	$36,394.31

Sincerely yours,

A. E. Larsen, M. D.,
Executive Medical Director.

Medical Dilemma in Housing Projects

California Physicians' Service to Quit Medical Centers on September 30

The California Physicians' Service is unable to continue treating sickness in the Federal housing projects in California.

So California Physicians' Service is quitting.

And the ills of tens of thousands of project tenants—800,000 in the Bay area alone—will become the responsibility of everybody else's family doctor.

The reason: California Physicians' Service is financially unable to continue its prepaid health program in housing projects.

That decision was reached after many weeks of conference by California Physicians' Service and all interested Federal agencies, which resulted in notice being sent to project managers that California Physicians' Service would withdraw its personnel and facilities on September 30.

For many weeks *The Chronicle*, through its page for war workers, *"Yanks on the Home Front,"* has been emphasizing the need for doctors and nurses in housing projects and citing the success California Physicians' Service has achieved in the projects it has served.

The California Physicians' Service decision means that twenty-two doctors and forty-nine nurses in projects at Marin City, Vallejo, Contra Costa, San Francisco, Los Angeles, and San Diego will pack up and leave in a month and a half. There was no California Physicians' Service system in projects other than those.

Heavy Losses

Without on-project medical centers, project tenants will be forced to seek medical attention from the already overworked doctors in near-by communities. There are fewer of those and many more patients.

California Physicians' Service has been losing heavily, according to Dr. A. E. Larsen, its director.

In May, for example, its income was $55,462, while its expenditures were $103,797—a 50 per cent loss. That month is typical, officials say.

Dozens of worried Federal officials and officers of medical associations are working on a plan to save California Physicians' Service centers in housing projects.

That plan, according to project executives, would include all tenants in all projects in California Physicians' Service prepaid health program and thus assure doctors and nurses for every tenant's needs.

So far, California Physicians' Service has extended its services to six California projects.

Cancellation Fear

Project executives are asking those tenants who are buying health protection from California Physicians' Service to continue making their monthly payments in the hope that the new plan will be approved by Federal Public Housing Authority officials in Washington.

California Physicians' Service doctors say that too few project tenants have volunteered to pay the monthly fee for health protection and that an enormous number of obstetrical cases has drained the California Physicians' Service treasury.

When the voluntary health insurance plan was worked out a year and a half ago, it was based on a birth rate of 17 births to each 1,000 individuals. In housing projects that ratio has zoomed to 100 births per 1,000 individuals.

Another factor in depleting the California Physicians' Service treasury, officials say, is the enormous number of workers, declared physically unfit by the military, who are now employed in shipyards and who need medical attention.

With 100 per cent enrollment, they say, all the needs of all the tenants can be met.

* * *

California Physicians' Service May Yet Be Saved!

Don't cancel your California Physicians' Service insurance! You may need medical attention between now and September 30.

That plea was directed to housing project tenants who are now benefiting from the California Physicians' Service prepaid health plan. (See accompanying story about the threatened dissolution of California Physicians' Service on project services.)

Don't cancel your California Physicians' Service insurance, housing officials say, because there is a chance the program may be saved.

To help save California Physicians' Service for housing project tenants, "Yanks on the Home Front" invites everyone who has benefited—and paid—for its services to write their experiences to *The Chronicle*.

Address your letter to "Yanks on the Home Front," *The Chronicle*, Fifth and Mission streets, San Francisco.—San Francisco *Chronicle*, August 13, 1943.

War Housing Projects Face Loss of Physicians' Service

Faced with mounting deficits in its housing fund, but still trying to find a way out "because the need is so evident and the medical profession recognizes it," the California Physicians' Service today was preparing to seek Federal assistance to continue its care of 60,000 persons in California housing projects.

"Unless we can make some adjustment, we will have to withdraw from our housing projects in Long Beach, Vallejo, Marin City, Richmond, and Hunters Point in San Francisco," Dr. Albert E. Larsen, medical director of California Physicians' Service, said today. "We already have withdrawn from the San Diego housing project, where the situation became financially impossible," he added.

Whatever decision is finally reached, with September 1 as the deadline, it will not affect the general operations of

the California Physicians' Service, Doctor Larsen emphasized.

California Physicians' Service was organized independently under auspices of the California Medical Association. Physicians and surgeons of the Association contribute their services on a pro rata basis, getting only partial pay when funds are low.

"Except in San Diego, where some doctors withdrew because of a dispute over the organization, we haven't had a doctor quit," Doctor Larsen said, "and don't forget that the doctors are the ones who are getting nothing and still are standing by because the need is great and they recognize it."

California Physicians' Service has established medical care centers in the projects, and last winter proved its value when it had but one case of pneumonia.

Obstetrical expenses have been the heaviest drain in the housing project funds, Doctor Larsen said. He said that while the national birth rate average is 22 per 1,000 persons, in the housing centers it has been 100 per 1,000. Furthermore, he noted, housing project occupants have been selected on the basis of need, and many have required expensive treatments.

Doctor Larsen and Langdon Post, regional director of the Federal Public Housing Agency, will leave for Washington to confer on the problem with officials of the FPHA following a conference here August 22 with the Council of the California Medical Association. They will seek approval and assistance in raising the monthly rates for childless couples from $4 to $6 and for families of three or more from $5 to $7.50. The fee for single persons would remain at $2.50.—San Francisco *News*, August 13, 1943.

California Physicians' Service and Federal Housing Authority

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

July 30, 1943.

To the Secretaries of the County Medical Societies:

Dear Doctors:

I am sure that all the members of your society will be vitally interested in the developments of the past two weeks in the arrangements between California Physicians' Service and the Federal Public Housing Authority for the furnishing of medical care to the occupants of federal housing units in the war industry areas.

In brief, California Physicians' Service has notified the Federal Public Housing Authority that it is financially impossible to continue giving medical care on the basis of the present contract and that unless additional funds are forthcoming for the payment of standard units to the professional members of California Physicians' Service, the contract must be canceled.

This notification has been placed before the Federal Public Housing Authority on a basis of urgency, with the full knowledge on the part of all concerned that unless satisfactory financial arrangements can be made within the next sixty days, California Physicians' Service will withdraw from the federal housing areas.

Earlier this week California Physicians' Service met with the representatives of the Federal Public Housing Authority, the local housing authorities in various areas, Procurement and Assignment Service, California Medical Association, U. S. Public Health Service, and several other Government agencies. The net result of this meeting was that all those present recognized the seriousness and urgency of the situation and agreed that more adequate financial arrangements must be provided by the housing authorities.

Those at the meeting adopted unanimously a resolution which requests the Federal Public Housing Authority to authorize the local housing authorities to negotiate contracts with California Physicians' Service on a basis which will allow California Physicians' Service to operate on a financially sound basis, with additional funds for such service to come from some source which is not now being utilized. Ways and means of raising adequate funds were left entirely in the hands of the housing authorities.

On the basis of the demand from California Physicians' Service to the housing authorities, it appears only reasonable to assume that within the next two months we can all count upon one or the other of two alternatives: (1) that professional members of California Physicians' Service will receive adequate payment of units of service rendered for housing area residents, or (2) that professional members of California Physicians' Service will no longer be asked to accept these patients on the basis of California Physicians' Service units.

From all indications we can look forward to a speedy settlement of this problem. It is hoped that our members will exercise due discretion and judgment in their own courses of action during this short period.

Meanwhile, the regular California Physicians' Service program continues the improvement noted some months ago, and we hope that your members will recognize the regular program as entirely separate from the housing area program and will continue their support of the improved regular program.

Fraternally yours,

PHILIP K. GILMAN, M. D.,
Chairman of the Council.

National Tuberculosis Association

In 1904 a group of four hundred far-sighted physicians and laymen organized the National Tuberculosis Association. Their fundamental purpose was to ultimately control tuberculosis. At that time they had no means of raising funds, nor were all communities being organized. As you may remember, in 1907 Emily Bissell borrowed the idea of the Christmas Seal as a fund-raising method. This resulted in coöperation between the American Red Cross and the National Tuberculosis Association until 1920, when the National Tuberculosis Association became the sole proprietor of this unique method of raising funds.

The National Tuberculosis Association, through annual contracts, authorizes the state, territorial, and local associations to conduct the seal sale and to carry on activities for the control of tuberculosis. Five per cent of the gross proceeds from all money raised by the local associations goes to support the National Tuberculosis Association.

The National Tuberculosis Association assumes leadership in formulating policies which ultimately will control tuberculosis. Their funds are expended on health education, research and study, organization and administration, and publications of medical and health education material.

Profession or Trade.—The medical profession deserves the grateful recognition and regard of all other callings in modern life. It has always insisted that the practice of medicine is a profession and not a trade. Trade is occupation for livelihood; profession is occupation for the service of the world. Trade is occupation for joy of the result; profession is occupation for joy in the process. Trade is occupation where anybody may enter; profession is occupation where only those who are prepared may enter. Trade makes one the rival of every other trader; profession makes one the coöperator with all his colleagues.—President Faunce, of Brown University, in an address to the Rhode Island Medical Society, 1905.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Place and date of the seventy-third annual session, to be held in 1944, to be announced later.

* * *

American Medical Association. Place and date of 1944 annual session to be announced later.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a. m., under the title "Your Doctor and You."

In August, KFAC will present these broadcasts on the following Saturdays: August 7, 14, 21, and 28.

The Saturday broadcasts of KECA are given at 10:45 a. m., under the title "The Road of Health."

"Doctors at War":

Radio broadcasts of Doctors at War by the American Medical Association in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy are on the air each Saturday at 2 p. m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Once Again, Here's to You, Herbert:* University of California Press, at $10, offers a choice collection of forty-eight papers on physiology of reproduction, nutrition, and endocrines, and on the history of medicine and science, *Essays in Biology in Honor of Herbert M. Evans.* From Allen, through Fulton, Houssay & Turpeinen, to Zondek, the essayists have given Herbert a grand sixtieth birthday. Don't miss one; they are all first class. The volume is a "must" for any library.

2. *Other Books:* H. F. Blum offers *Photodynamic Action and Diseases Caused by Light,* an excellent survey (Reinhold Publishing Company, New York City, $6). F. J. Wampler edits for Williams & Wilkins, Baltimore, $6, the *Principles and Practice of Industrial Medicine,* with chapters by thirty-two experts. Basic and hot is H. A. Abramson, L. S. Moyer, and M. H. Gorin's *Electrophoresis of Proteins and the Chemistry of Cell Surfaces* (Reinhold Publishing Company, New York City). Tops is *Proteins, Amino-Acids and Peptides as Ions and Dipolar Ions,* by E. J. Cohn and J. T. Edsall (Reinhold Publishing Company, New York City). The Commonwealth Fund (41 E. 57th Street, New York 22) issues D. O'Hara's *Air-Borne Infection: Some Observations on Its Decline.* On the sweetness and light side is B. W. Overstreet's *Courage for Crisis* (Harper's, New York). J. B. Lippincott, Philadelphia, refer to L. K. Ferguson's *Surgery of the Ambulatory Patient* as the book of the year. From the Macmillan Company, Cambridge University Press Division, New York City, comes the announcement of the intriguing *Anonymous Londinensis,* a translation by W. H. S. Jones of second century papyrus, giving extracts from twenty-five ancient medicos. Also, for $5.50, the important *Permeability of Natural Membranes,* by H. Davson and J. F. Danielli. And C. E. Raven's *Science, Religion, and the Future.* Noticed the increase in manuals of tropical medicine and parasitology? Annual Reviews (Vol. XII, Biochemistry; Vol. 5, Physiology, Stanford University, California) are up to their usual standards. For the American Library Association, Chicago, Janet Doe of the New York Academy edits a *Handbook of Medical Library Practice,* which, let us hope, will not become pontifical.

3. *Shock:* F. R. Winton & Co. describe injury to kidneys from traumatic shock (*Quart. Jour. Exp. Physiol.,* 32:89, 1943). M. C. Winternitz & Co. show significant rise of serum phosphate in traumatic shock and demonstrate shock-like symptoms from phosphate administration, and then indicate beneficial effect of intravenous sodium succinate (instead of glucose) with plasma (*Am. Jour. Physiol.,* 139:299-324, 1943).

4. *Cancer:* J. K. Parnas succinctly reviews coenzymatic reactions (*Nature,* 151:577, May 22, 1943). The excellent work of the McArdle Laboratory at Wisconsin results in W. C. Schneider and V. R. Potter proposing theories of biocatalysis in cancer tissue (*Cancer Res.,* 3:353,1943). I. H. Perry, L. A. Strait, and E. L. McCawley put across a neat California report on a spectrochemical study of estrogen-induced mammary cancer (*Ibid.,* pp. 370-384). C. Huggins discusses the endocrine control of prostatic cancer (*Science,* 97:541, June 18, 1943).

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School, Galveston, Texas.

5. *Alia:* W. Hughes and F. Murgatroyd discuss drug control of malaria (*Lancet*, 244:699, June 5, 1943). Vale to Warrington Yorke (1883-1943), brilliant chemotherapist! M. M. Sheniakin & Co. (Moscow) (*Nature*, 151:585, May 22, 1943) also propose a redox mechanism for vitamin K activity, like E. L. McCawley and C. Gurchot (*Univ. Calif. Pub. Pharmacol.*, 1:325, 1940). E. C. Dodds & Co. naturally would note morphine-like action of diphenylethylamines (*Nature*, 151:614, May 29, 1943). W. S. McClellan of Saratoga Springs would also naturally observe new trends in the treatment of chronic disease, recounting an experience in Spa therapy (*Ann. Int. Med.*, 18:825, 1943). E. A. Doisy & Co. report that penicillin B is a flavoprotein enzyme causing oxidation of glucose to gluconic acid and hydrogen peroxide, the latter being antibacterial (*J. Biol. Chem.*, 148:365, 1943). The J. R. Gallaghers and L. Brouha give dope on dynamic physical fitness in adolescents (*Yale J. Biol. Med.*, 15:657, 1943). G. A. Emerson finds that ventricular fibrillation from digitalis is not adrenergic (*Proc. Soc. Exp. Biol. Med.*, 53:12, 1943).

Doctors of Medicine as Others See Them.—"During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest."

The above item, with some quotations, appeared in CALIFORNIA AND WESTERN MEDICINE: July, 1942, issue, pp. 108-109; October, pp. 269-270; November, pp. 287 and 331-332; January, 1943, issue, pp. 49 and 50; February, pp. 92-93; April, pp. 255-257; May, pp. 305-308; and July, p. 96. More recent items follow:

A Tribute to Medical Men: Praise From a General

Lieutenant General Lesley James McNair, Commander of Ground Troops in the United States, wounded while visiting the African front, had the following to say of the American doctors in that scene of action: "The medical service was superb. I know at first-hand the speed and efficiency with which they worked. I was wounded at 2:30 in the afternoon. Within ten minutes they had me at a Battalion Aid Station. There two medical officers put a tourniquet on my shoulder to stop the bleeding, bandaged me, fixed me up so I could be taken to the rear. I went from there in a jeep to the Division Clearing Station, where they gave me blood plasma and checked my dressing. They put me on a litter in an ambulance and started me farther to the rear. At 5:30, only three hours later, I was in a field hospital, had been treated twice, had had x-rays taken, and was ready to be operated upon. That evening I came to in a warm bed, with no after-effects from the operation. . . . I didn't get this sort of treatment because I was a general officer. Buck privates were getting the same care."

The medical men who attended General McNair in Africa were merely civilian doctors not many months ago following routine practices at home. The service which they are now rendering to the troops—general and private alike—they were rendering to civilians. On the military front, as on the home front, these medical men know only one kind of service—the best possible. That is the tradition in which they have been trained.—San Francisco *Organized Labor*, July 17.

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True to Tradition

American doctors have long been leaders in alleviation of human suffering. True to tradition, they are now giving unparalleled medical service to our soldiers at the front. Brigadier General George F. Lull, personnel officer in the Surgeon-General's office, estimates that 3,000 American doctors will be disabled every year in service, and be returned to civilian life. The doctors are right with the fighting men getting the wounded off the battlefield and from there to base hospitals. It is the remarkable rapidity with which men are cared for after their injuries that has caused the miraculously low mortality rate in American casualties.

Based on the initiative American Medicine has shown in bringing the benefits of medical science to all the people, the record it is making in this war is but logical progress toward the goal it is constantly seeking to reach—the maximum saving of life and elimination of suffering.—Chico *Enterprise*, July 6.

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Services of Physicians Reassure

My hat is off to our American medical men in the service and on the home front alike. Figures recently released by the Government on the percentage of recoveries from wounds in the present conflict reveal an interesting and encouraging picture.

Certainly it should be a source of comfort to the parents and relatives of the boys in the armed forces to know, for instance, that approximately 53 per cent of those who were wounded up to a recent date had been returned to duty and that about 43 per cent were still under treatment in Army and Navy hospitals. Less than one per cent were invalided from service and deaths occurred in slightly more than two per cent of the cases.

All of this speaks most highly for the advancement of medicine and the skill and training of the physicians and surgeons now in active service and those at home who are discovering new cures and methods by constant study and long hours of work and research.

There are many life-saving devices entrusted to the men themselves and to the hospital corpsmen which may account for a high percentage of saving and sustaining life until the nurses and doctors arrive upon the scene.

For instance, the first-aid packet which contains certain tablets of an improved sulpha ingredient, and sulpha powder to be used on wounds. These kits are so arranged that a wounded man may open and apply them if necessary before the hospital corpsmen arrive.

When one considers that modern warfare does not have rigid and distinct battle lines and that opposing forces are continually on the move back and forth, from flank to flank, over mountains and down valleys, one begins to grasp the mobile and flexible attributes of the modern medicine and hospital units and the war training which medical officers and nurses must undergo.—Sonora *Union Democrat*, July 9.

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Will Not Forget

It is often said that war is harder for those who remain behind than for those who go. Millions are now experiencing the sleepless nights, the ceaseless worry of remaining at home while others go to war. No small source of concern over loved ones in the service is the fear that they may not receive proper medical care. This can be dispensed with. The men in military service are receiving the best that medical science can give them.

In reviewing the military medical record of the first year after Pearl Harbor, *The Journal of the American Medical Association* says: "During the year the only serious incident from a medical point of view was the jaundice associated with inoculation against yellow fever. The first week of February, 1943, found atypical pneumonia and meningitis most prominent of the infectious diseases, but even these were scattering, with a few cases here and there, and only a score or slightly more of cases of either in the few

camps most seriously affected. . . . Since January, 1941, and up to now, excluding battle casualties, the death rate has been the lowest in the history of our Army. During World War I, one patient of each three with meningitis died; now only one in twenty dies. Prompt diagnosis, efficient care and sulfonamides have made the difference."

The American public owes a debt of gratitude to the medical men that it will never be able to fully repay. The countless thousands of men who will return after the war, thanks to the skill of doctors serving in the front lines, will not forget that debt.—Corning *Observer*, June 23.

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The Doctor Goes Aloft

A few years ago the dreams of men who proposed four hundred mile an hour combat planes which functioned efficiently at 40,000 feet would have been scoffed at as impossible. Even if the planes were devised capable of such performance, what of the human element? It was thought no person could stand the strain. No person could then. But medical science managed to keep abreast of aircraft development. Planes and men fight today in the stratosphere at ear-splitting speeds. They fight at altitudes where the air is so rare, exposure means death in a matter of seconds.

It was recently pointed out in *Hygeia* that "An airman—this applies to men on the ground staff as much as to flying crews—who is obviously suffering from strain finds in the medical officer a personal friend anxious to assist him in every respect. The doctor usually knows most of the flying men of his squadron by name. By studying their records, documents, and flying logs, he can always keep himself informed of their progress."

It is no idle assertion that modern air power is dependent upon modern medicine.—Isleton *Delta News*, July 2.

* * *

While Others Cheer

When the prospect of peace becomes more real, literally hundreds of millions of people will stand ready to join in a deafening tumult of relief and happiness. Victor and vanquished alike will revel in a reunion with loved ones.

But there is one group whose shouting will be muted—the doctors. For them the job of rebuilding the shattered wreck that humanity has made of itself and the world will begin. Many of them will not be able to return home. They will have to stay in far-away places battling as they never battled during the war, against disease and starvation. They will have to work against time to develop new aids and new techniques in a world-wide struggle to control the spread of fearsome maladies. These men in white know that the war has created medical problems which if not solved could easily make the war itself look like a pink tea. No, the doctors will not cry out in care-free happiness when this war ends.

Laymen, who know so little of the grim task the doctors face, should endeavor to ease their burden wherever possible. The standards of our medical men are high. They serve rich and poor alike to the best of their ability, and the ability of American doctors is not surpassed. We should reflect soberly on these things in the years ahead when the doctors will be fighting the greatest battle of all time.—Woodland *Echo*, July 30.

Four-County Medical Society Meeting at Sonoma Golf Club.—On Thursday evening, July 29, at the Sonoma Golf Club, the annual Four-County meeting (Sonoma, Solano, Napa, and Marin counties) was held. The meeting was given over to goodfellowship and a discussion of organization topics. Dr. William N. Makaroff of Guerneville presided.

Talks were made by: Karl L. Schaupp, President of the California Medical Association; Dwight H. Murray of Napa, Chairman of the California Medical Association Committee on Legislation; Councilor John W. Green of Vallejo; Past President Henry S. Rogers of Petaluma; Secretary-Editor George H. Kress; Legal Counsel Hartley F. Peart; Executive Secretary John Hunton; Secretary of California Public Health League, Ben Read.

The occasion was graced by a goodly number of colleagues in military service who had come over from the Mare Island Hospital and other posts.

State Senator Herbert W. Slater of Santa Rosa, who was also one of the speakers, emphasized the importance of keeping legislators properly oriented on public health needs.

Rationed Foods for Hospital Patients.—While the wartime need of conserving rationed foods is great, no hospital patient need suffer from inability to get foods required for his health, the Office of Price Administration recently announced.

The OPA is sending specific instructions highlighting this point to all local War Price and Rationing Boards, and to other OPA field offices. For several months, OPA and medical authorities have been studying the hospital problem with a view to developing a uniform procedure covering the granting of supplemental allotments for hospitals. Solution of the problem is believed near.

"In the meantime," OPA said, "a provision in the regulations (Section 11.6 of General Ration Order 5) should enable hospitals to obtain the necessary supplemental allotments so that no patients shall suffer from dietary deficiency. This provision gives local boards authority to grant such allotments to meet the dietary requirements of patients living in, and receiving care in, hospitals, whether or not such patients are on special diets.

"In determining the amount of the supplemental allotment of processed foods and the commodities covered by Ration Order 16, the local board will take into consideration the availability of fresh fruits and vegetables, unrationed substitutions such as poultry and fresh fish, and the physical facilities of hospitals to process and store such foods."

Administrative officers of hospitals had complained that local boards in some cases had confined the granting of supplemental allotments to situations covering patients on special diets.

"Section 11.6 of the ration order does not limit the granting of relief so narrowly," OPA explained. "No hospital patient need suffer from inability to get food because of rationing."

Notes from the Food Rationing Committee of the San Francisco County Medical Society.—The Medical Advisory Committee of the Food Rationing Division of the OPA has met regularly each Thursday evening and has checked many special food applications. In general, the requests for extra rations have been most reasonable and conservative. Certain suggestions have presented themselves:

1. The Advisory Committee, desirous of coöperating with our Government's food plans, believes that it is necessary to use all precaution in the conservation of processed foods, particularly at this time. The Committee is convinced, after due investigation, that water-packed fruits and vegetables are not essential in a diabetic diet when fresh fruits and vegetables are available. Fresh fruits and vegetables are incorporated in measured diets with the same facility as are water-packed materials. It is, therefore, urged that physicians do not request water-packed foods for diabetic patients except when complicating factors de-

mand them; such complicating factors should be stated plainly and concisely.

2. In requesting additional meat, it is extremely important to specify the type; that is, beef, veal, lamb, pork or liver, as the point value on beef is practically double that of most of the meats. Likewise, beef should not be specified except where it is most essential, as the supply is very limited and the patient may not be able to obtain the beef for which he has points.

3. Please request foods in pounds or ounces rather than points, as point values change constantly.

4. Please prescribe extra foods on the basis of medical diets rather than upon an economic basis.

American Board of Otolaryngology.—Attention is directed to the letter printed in the July issue of CALIFORNIA AND WESTERN MEDICINE, on page 103, in which the following announcement was made:

"The American Board of Otolaryngology will conduct an examination in Los Angeles on February 2 to 5, 1944, following the meeting of the Midwinter Clinical Course of the Research Study Club, provided at least fifty applicants are accepted. It is urgently requested that applications be submitted immediately so that the Board may plan accordingly. Address all applications to Dean M. Lierle, M. D., Secretary-Treasurer, University Hospital, Iowa City, Iowa.

"The Thirteenth Annual Midwinter Postgraduate Clinical Course of the Research Study Club of Los Angeles will be given from January 17 to 28 inclusive, 1944, to be succeeded by the special course in Applied Anatomy and Cadaver Surgery of the Head and Neck, to follow immediately after the Clinical Course. Both courses afford an unusual opportunity for members applying to the American Board of Otolaryngology to obtain an up-to-the-minute refresher course just prior to their examination."

Dinner to Dr. Esther Rosencrantz.—Honoring Dr. Esther Rosencrantz, a formal dinner was given by fifty of her medical colleagues at the Palace Hotel, San Francisco, Friday, July 9, the occasion for the testimonial being her retirement from the University of California Medical School after thirty years' service.

For seventeen years, between 1920 and 1937, Doctor Rosencrantz was Chief of the Tuberculosis Service at the San Francisco City and County Hospital; and at the time of her retirement she was associate professor of medicine and lecturer in medical history and bibliography at the Medical Center in San Francisco. The following is a résumé of her record:

Dr. Esther Rosencrantz, '04, Johns Hopkins, after her intern year at the New York Infirmary for Women and Children, was assistant in the out-patient department of Brompton Hospital for Consumption and Diseases of the Chest, London, England, in 1906-07. She worked two years at the Tuberculosis Clinic, New York City Health Department, and then spent a year at the Charité Hospital, Berlin. From 1910-11 she was a research worker at the Pasteur Institute, under Calmette; then for a year was intern at the Sanatorium de Bligny, France, and after that research worker at Insel Spital, Berne, Switzerland, under Professor Sahli. From 1913-37 she was on the staff of the University of California Medical School, and retired as associate professor of medicine. From 1920-37 she was in charge of the Tuberculosis Service at the San Francisco City and County Hospital. Her greatest honor was a decoration from the Italian Government in recognition of her splendid services as a member of the Red Cross Tuberculosis Commission to Italy in 1918-19. Later Doctor Rosencrantz was consultant to the Arequipa Sanatorium, San Luis Obispo County Tuberculosis Sanatorium, Hassler Health Home, and the Tuberculosis Service of the University of California Hospital and the San Francisco Hospital.

The following doctors were speakers at the dinner: Philip H. Arnot, Jessie L. P. Delprat, Herbert M. Evans, Jacob C. Geiger, Portia Bell Hume, Robert T. Legge, Sophie M. Loven, Earle M. Marsh, Karl M. Meyer, and Angelina Piscitelli. Dr. Jesse Carr was toastmaster.

Doctor Rosencrantz has been a noted collector of the works of Sir William Osler, whose pupil she was at Johns Hopkins Medical School; and at the dinner in her honor she was presented with six of the rarest Osler items. Doctor Rosencrantz has given her Osler collection to the University of California Medical School. At the dinner Dr. Hans Barkan, of the Stanford University Medical School, presented for the collection an original portrait-sketch of Sir William Osler by the famous painter, John Singer Sargent.

Noncongestive Glaucoma: Prize Contest.—The National Society for the Prevention of Blindness announces that a prize of $250 will be awarded for the most original paper adding to the present knowledge about medical treatment of noncongestive glaucoma. Papers should be in the office of the Society, 1790 Broadway, New York City, by September, 1944. (This prize is being offered in addition to one that was previously announced for the most valuable original paper concerning the diagnosis of early glaucoma.)

The award will be made by the Society with the guidance of an ophthalmological committee composed of Doctors Evans, Keil, Kirby, McLean, Reese, Samuels, Schlivek, Schoenberg, and Webster.

American Congress of Physical Therapy.—Will hold its twenty-second annual scientific and clinical session on September 8, 9, 10, and 11, 1943, inclusive, at the Palmer House, Chicago. Rehabilitation is in the spotlight today. Physical therapy plays an important part in this work. The annual instruction course will be held from 8:00 to 10:30 a. m. and from 1:00 to 2:00 p. m. during the days of September 8, 9 and 10, and will include a round-table discussion group from 9:00 to 10:30 a. m., Thursday, September 9. The scientific and clinical sessions will be given on the remaining portions of these days and evenings. A feature will be an hour demonstration showing technique from 5:00 to 6:00 p. m. during the days of September 8, 9, and 10. All of these sessions will be open to the members of the regular medical profession and their qualified aids.

For information concerning the instruction course and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

Our Mineral Springs.—Awaiting development in times of peace as among the greatest natural resources are the four hundred or more natural springs in California.

The healing values of some of these springs have been proved through years of use and trial. In the belief that with the close of the war there will be increased opportunities to bestow benefits, our State Chamber of Commerce, the League for the Development of California's Mineral Springs, the State Legislature, and others, are directing new attention to assets of a kind which in other countries have been highly valued and internationally publicized.

Practically all that which has been done in the interest of promoting our springs was started four years ago when the State Chamber placed the program on its agenda, and two years ago when the League was organized. These were programs of normal times, anticipating no federal coöperation, and stressing largely the attractions which would be offered to tourists.

At present, it is believed that many of these springs, with their values authenticated, will render services much larger. For that reason, the recent Legislature, by joint resolution, has asked the President, members of Congress from this State, and the surgeons general of the Army and Navy to institute investigations concerning the advantages that would accrue to the patients if one or more military hospitals of convalescent or other nature were erected in the mineral springs areas.

It may well be that some of these springs, which were known to the Indians for their properties long before the white men came may offer special advantages in recovery of the health and rehabilitation for invalid soldiers and sailors suffering from shock or nervous or other disorders incident to the war experiences. If there is that possibility, it is entirely proper that the State ask the medical authorities of the military, and others, to undertake an inquiry.

In European countries and in the United States, at Saratoga Hot Springs in New York, and in Arkansas, mineral springs and the spa treatment have been abundantly tested and approved. The springs of California, situated among beautiful surroundings and in a region of beneficent climate, have long awaited recognition and the chance to demonstrate their values.

For some years, it would seem certain, Americans who used to follow the impulse will not be able to visit the spas of Europe, and for some years it will be the duty of this country to supply the best of care and environment to the convalescents of the war. In the program the mineral springs of California may be destined to have a large part.—Oakland *Tribune*, June 2, 1943.

Gestation Data for Guidance of Draft Boards.—For the guidance of draft boards, the American Medical Association on May 7 said that if the father of a child born after September 15, 1942, claims that the infant was conceived before Pearl Harbor, the burden of proof should rest with the father.

The American Medical Association Journal said that children born after the September 15 deadline could be assumed safely to have been conceived after December 8, 1941, unless there is overwhelming medical evidence to the contrary.

Recent studies of 9,000 women have set the average period of gestation at 285 days, the *Journal* said.

"French law recognizes the legitimacy of a child born 180 days after marriage and 300 days after the death of the husband; the German law, 181 days and 302 days, respectively. In England, in 1921, the legitimacy of a child born 331 days after the husband went to war was allowed. In the United States each case is decided on its own merits."

American Longevity Continues to Increase.—The average length of life of the American people has increased by almost one-third since the beginning of the century. According to health conditions prevailing in 1941, the people of this country had an average length of life, or expectation of life at birth, of 64.36 years—a gain of more than fifteen years since 1901. The record has been especially good for white females, who, in the last four decades, have added 17 years to their expectation of life at birth, as against 15.16 years for white males. By 1941, white females attained an average length of life of 68.08 years, just two years short of the biblical three score and ten. For white males the figure was 63.39 years, or about 4⅝ years less than that for white females.

The record shows that colored persons have made greater gains in longevity than have the white. The expectation of life at birth for the colored increased by 21⅓ years since the turn of the century, while the gain for white persons amounted to 16 years. This fact notwithstanding the current longevity among colored persons is still ten years less than that for the white, and is now only at the level of that for white persons a quarter century ago.

The most substantial gains in extending the average length of life have been made in childhood, adolescence, and early adult life. Stated in terms of mortality, the rates in 1941 at ages below 40 were well under one-half those at the beginning of the century. In the first year of life and at ages from 10 to 30, the current rates are one-third those in 1901; at age 5 they are only one-fifth. One must not assume, however, that death has retreated only at the younger ages. Improvements in mortality have been appreciable even after age 40. For example, at age 45 the death rate in 1941 was three-fifths that in 1901; at ages 50 and 55 the ratio was about three-quarters. The gains in expectation at age 40, by sex and color, are given in the right-hand panel of Table I. These figures give little comfort to the prophets of doom, who claim that the race is deteriorating physically because scientific and social advances interfere with the laws of natural selection. On the contrary, such conservation of our human resources contributes basically to our security.

As a result of the current favorable health situation, about 60 per cent of the large crop of babies now being born will live to attain age 65; according to conditions prevailing in 1901 only 40 per cent might have been expected to attain that age. It is possible to make an even more graphic contrast of the change in longevity that has taken place. Mortality in 1901 was such that one-quarter of the babies would have died before attaining age 25. But with the conditions in 1941, age 57 would be reached before that proportion died.

Although 1941 is the best year on record as regards longevity, there are indications that when the figures for 1942 become available they will show an equally good record. On the whole, health conditions have been very favorable despite the growing shortage of civilian physicians, the initiation of restrictions on food consumption, and the crowding of people in centers of war industries with inadequate housing facilities. . . .—Metropolitan *Statistical Journal*, April, 1943.

Compulsory Sickness Insurance.—"A. W. Eckman, at the meeting of the Christian Science Church in Boston on June 7, 1943, manager of the committees on publication, reported that state, provincial, and national legislative bodies had dealt fairly with Christian Science activities. But he cautioned that there was an increasing tendency in legislative halls to impose blanket regulations involving compulsory sickness, disability and hospital insurance which would bring about indirect compulsion upon Christian Scientists to accept medical treatment."—San Francisco *Chronicle*, June 8, 1943.

State Attorney-General Kenny Rules on Drugless Practitioners.—Drugless practitioners may legally sign death certificates, Attorney General Robert W. Kenny ruled yesterday in an opinion given to the Board of Medical Examiners.

"A drugless practitioner receives his license from the Board of Medical Examiners," Kenny wrote. "By law, the mode of treatment employed by him is recognized. It is difficult for me to believe that a drugless practitioner in attendance on a patient should not be qualified to file the certificate of death as well as the medical certificate.

"It should, of course, be realized that the implication is not to be conveyed that drugless practitioners may call themselves or advertise themselves as 'physicians' or that they may practice 'medicine.' "—Los Angeles *Daily News*, June 23.

Lemon Now Is Source of Pectin.—Now you can get a transfusion from a lemon.

Before you hasten to build up your blood supply by taking your lemons in a medicinal mixture from a tall glass, be warned that the lemons are first reduced to pectin, in which form it is valuable replacement for blood plasma.

A two months old rabbit who probably wouldn't even twitch his nose at a lemon of his own accord is thriving with one-third of his rabbit blood replaced by the lemon kind—sterile pectin solution.

The California Fruit Growers' Exchange, who calculatingly converted the nation to drinking up an orange surplus, thought it up. Their laboratory and clinical studies were confirmed by less citrus-minded medical authorities.

The April 24 issue of *The Journal of the American Medical Association* reports on use of lemon pectin instead of plasma in treatment of human beings suffering shock.—Santa Cruz *Sentinel-News*, May 6.

2,628 Gain Made in Doctor Total.—There was a net gain of 2,628 physicians in the United States last year, *The Journal of the American Medical Association* reported.

Statistics gathered by the American Medical Association's Council on Medical Education and Hospitals, and based on new licenses and certificates issued in 1942, showed 5,981 physicians were added to the profession's population. During the same period, 3,353 deaths were recorded.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Social Change To Be Slow, Senator George Says

Vienna, Ga., July 31.—(AP)—Senator Walter F. George (D., Ga.), chairman of the Senate Finance Committee, commended today President Roosevelt's six-point plan to aid returning service men, but predicted that the Congress would be cautious in expanding the nation's social security program.

Observing that existing laws provide for rehabilitation of soldiers and sailors after the war, George suggested in an interview that the President "has in mind a greatly expanded social security program."

"Notwithstanding the great humanitarian impulse to greatly extend the social security system," he continued, "we will proceed slowly in the United States to expand any program which is dependent on a capital levy."

He argued that social security taxes must be paid by business whether it runs in the black or in the red, and thus is capital taxation.

"With a sound system of taxation that allows individuals and business to accumulate reserves, we should be able to provide reasonable employment for our people as we have in the past except in periods of unusual depression. A social security system, properly enacted, would soften the blow in such periods.

"Any social security system must depend on prosperous business—all business, from farming on up the scale—and if we haven't got prosperous business, we cannot have social security on the European scale.

"If we have prosperous business, we don't need to make the people dependent on their government. That, at least, is the American way, and if that passes, we will go to a different social and political system in America."—San Francisco *Chronicle*, August 1.

State Population of 10,000,000 Is Predicted for California

Sacramento, July 21.—(UP)—Barring unforeseen catastrophe, a California population of 10,000,000 is inevitable by 1950, according to a survey completed today by the State Population Commission.

The report said California was probably third among the States now, having passed Ohio and Illinois since the 1940 census, and predicted that by 1960 it might overtake and pass New York.

California's growth since 1940 was estimated at about 1,000,000, but the commission warned that the State must prepare for an even greater "migration invasion" after the war.

It said that more than 400,000 persons have entered the State by bus lines already this year, and estimated another 400,000 had come in by private automobile.—San Francisco *Chronicle*, July 22.

Health Group Meets: Discusses Poliomyelitis

With eighty-two cases reported in the State, northern California health officials will meet in San Francisco today to consult with Dr. John L. Lavan, research director of the National Foundation for Infantile Paralysis.

State, county and city health officers will attend the meeting, which will be followed on Monday by a similar conference in Los Angeles for southern California medical men.

As the number of cases in the Bay area rose to twenty-five for the week ending July 10, directors of the San Francisco chapter of the Infantile Paralysis Foundation voted $6,000 to equip a ward for polio patients at Children's Hospital during the present emergency.

Health Officer Dr. William A. Powell reported fifteen new cases of infantile paralysis in Contra Costa County since July 1, compared with five in June.—San Francisco *Examiner*, July 15.

Nursing Education Must Be Streamlined

Berkeley, Jluy 26.—Nurses must be prepared more rapidly to supply the needs of the armed forces, according to Miss Margaret A. Tracy, director of the School of Nursing on the Berkeley and San Francisco campuses of the Universty of California. . . .

Training of Red Cross nurses' aides has shown that the nursing techniques on which a student normally spends 75 per cent of the time can be mastered in a relatively short period by intelligent individuals. There are differences of opinion as to how much time should be required in practice in the various clinical fields. By shortening the interval in each it might be possible to save as much as one year in the nursing course, she says.—*University of California Clip Sheet*, July 20.

U. C. Will Participate in Cadet Nurse Plan

Berkeley, July 21.—One of the participants in the new nursing education program subsidized by the United States government will be the School of Nursing of the University of California. This announcement was made by Miss Margaret A. Tracy, director of the School of Nursing on the Berkeley and San Francisco campuses.

To be known as the U. S. Cadet Nurse Corps, this organization of student nurses was established by a recent act of Congress. The purpose is to supply nurses for civilian health services as well as for the Army and Navy.

The entire cost of the nursing education is to be borne by the Federal Government. This includes uniforms, tuition fees, and monthly allowances to the students. In return, every member of the corps must agree to remain in nursing service for the duration. This does not necessarily mean the Army or Navy nurse corps, but may be any essential or public health nursing field.

Students who join the corps must be high school graduates and must satisfy the requirements of the nursing school in which they register.—*University of California Clip Sheet*, July 20.

U. S., Soviet Doctors Plan Coöperation

Wounded soldiers throughout the fighting world, and the sick and suffering for years to come, will know the healing effects of the American Soviet Medical Society, officially launched at dinner in the Hotel Pennsylvania Friday night.

This latest advance in Soviet-American relations brought together more than six hundred distinguished American medical leaders who will coöperate with Soviet doctors for the exchange of medical information through the society, and the American Review of Soviet Medicine, the new magazine which will appear in September.

The guest of honor was Dr. Vladimir V. Lebedenko, leading Soviet military surgeon, in this country as representative of the Red Cross and Crescent of the U. S. S. R.

Describes Soviet Care

"The secret of what Soviet medicine has accomplished," said Doctor Lebedenko, "is largely the secret of organization, plus the putting into operation on a large scale of everything science has achieved." He described how Soviet medical advances have enabled 75 to 80 per cent of the wounded to return to service.

Doctor Lebedenko paid tribute to the president of the new society, Dr. Walter D. Cannon, Professor Emeritus of Physiology, Harvard, and a member of both the United States and the U. S. S. R. Academy of Sciences.

Practically every branch of medicine, and every race and creed have joined to launch the American Soviet Medical Society.

Dr. Henry E. Siegrist, director, Institute of the History of Medicine, Johns Hopkins University and editor of the new magazine, was chairman. Maurice Hindus told of his experiences at the Soviet fighting fronts. . . . —San Francisco *People's World*, June 24.

Doctor Brockway Takes Over Riverside Clinic

Dr. Alvia Brockway, assistant chief of staff of the Orthopedic Hospital, Los Angeles, conducted his first clinic for the Riverside County Health Department Wednesday at the Community Hospital.

Doctor Brockway takes the place of the late Dr. Robert L. Carroll, who made semi-monthly visits to Riverside over the past five years. . . .—Riverside *Enterprise*, July 9.

Women Advised to Follow Medicine

New York, July 22.—(AP)—If it's a high paying job milady's looking for, the medical profession is the best bet and New Mexico is the spot to set up business.

So says the National Federation of Business and Professional Women's Clubs which surveyed the feminine employment field and found women physicians on top followed, in the professional field, by lawyers, accountants and librarians.

Teachers, for the most part, struggle along in the lowest income brackets, the federation said. In clerical jobs, secretaries lead, but stenographers and bookkeepers are fairly close in earning power.

Federation members, classified according to states, show proportionately more women in New Mexico than in other states are making over $10,000. Washington, D. C., and New York follow.

In Vermont, however, 47.3 per cent of those reporting earn less than $1,000. Proportions in this category are almost as high for Arkansas and Kansas.

Of 227 doctors, surgeons and osteopaths covered in the survey, thirty-seven reported $5,000 to $10,000 yearly incomes. Eight said they made more than $10,000.

The average physician's pay is $2,835.50 as against $1,547.50 for the entire professional group and $1,408 for business and professional women combined.

More than half of the school teachers reporting draw less than $1,500 a year.

Out of more than two thousand secretaries, seven are in the $5,000 to $10,000 bracket and two earn more than that.—Fresno *Bee*, July 22.

Diplomas for Sixty-One Doctors

Sixty-one young doctors who during the last year have completed their internship at the Los Angeles General Hospital and who are now serving in the armed forces, are soon to be mailed diplomas, Arthur J. Will, director of county institutions, announced today.

Will said the county hospital is playing a major rôle in training doctors and nurses for the military. He said there were double the number of internes and nurses in training now than in normal times.

"Just as soon as they complete their internship they are inducted into the armed forces and it is almost impossible to retain a few as resident physicians," Will said.—Los Angeles *Herald and Express*, July 23.

Thomas Jefferson on War.—We fight not for glory or for conquest. We exhibit to mankind the remarkable spectacle of a people attacked by unprovoked enemies, without any imputation or even suspicion of offense. They boast of their privileges and civilization, and yet proffer no milder conditions than servitude or death. In our native land, in defense of the freedom that is our birthright and which we never enjoyed till the late violation of it, for the protection of our property acquired solely by the honest industry of our forefathers and ourselves, against violence actually offered—we have taken up arms. We shall lay them down when hostilities shall cease on the part of the aggressors and all danger of their being renewed shall be removed, and not before.—Thomas Jefferson in 1775.

And there I began to think, that it is very true which is commonly said, that one half of the world knoweth not how the other half liveth.

—Rabelais, *Works*. Bk. ii, ch. 32 (1532).

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Judicial Control of Disciplinary Action by the State Board of Medical Examiners

The extent of control which a court may properly exercise over a decision of an administrative board, such as the Board of Medical Examiners, has been a troublesome question in California for some time.

The problem has been twofold: first, the nature of the remedy in the courts to one aggrieved by an order of such a board; and, second, the scope of that remedy.

Because of numerous decisions that an administrative board could not exercise judicial functions, and could not act as a court of law, it was held that no direct appeal could be taken to a court from a decision by a State Board disciplining a member. It was determined that the proper remedy, if a person desired to place before the courts the action of a board, such as the Board of Medical Examiners, was an application to the Superior Court for a writ of mandamus wherein an applicant who had been deprived of his professional license sought an order of the court directing the board to restore his license.

The question which then arose was the importance to be accorded by the court to the hearing before the State Board, and whether the court was confined to a consideration only of the evidence presented before the board with no power to hear new evidence presented by either side. It was held in two cases—one involving the State Board of Funeral Directors and a second, involving the State Board of Optometry—that the Superior Court, in considering an application for a writ of mandamus overruling the action of the State Board, was not confined to the record of the proceedings before the Board, and that the applicant was entitled to a completely new hearing before the Superior Court, designated a *trial de novo*.

A recent decision of the State Supreme Court, *Dare* vs. *Board of Medical Examiners*, 21 A. C., 854, further interpreted this rule as applied to the Board of Medical Examiners. The petitioner in that case alleged that he was licensed as a drugless practitioner under a certificate issued by the Board of Medical Examiners; that he was licensed to practice chiropractic under the provisions of the Chiropractic Act, and that he held a certificate as a clinical laboratory technologist. In May of 1940, he was charged with displaying a sign using the prefix "Dr." without indicating the type of certificate held. Proceedings were taken before the Board of Medical Examiners, and it was determined that this act constituted a violation of the Business and Professions Code, Section 2409. The Board ordered petitioner's license as a drugless practitioner revoked unless he would agree not to use any form of advertising or designation except the words "Drugless Practitioner." The petitioner brought a proceeding in mandamus, seeking an order by the Superior Court directing the Board to cancel this order.

At the trial of the case, petitioner contended there was no necessity for presenting the record of evidence introduced at the hearing before the Board, and that he was entitled to an entirely new trial by the court, with evidence being heard anew and no consideration being given to the Board's record.

If such a contention had been sustained, the effect would have been to vitiate the acts of the Board and render all

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

proceedings before it meaningless. Notwithstanding the court's warning, the petitioner insisted upon a right to a complete trial *de novo*, and refused to introduce the record of the Board.

Justice Shenk pointed out, in the court's majority opinion, that although the Superior Court in such a proceeding is not confined to the record of the evidence before the Board and can hear all competent evidence material to the issue involved, it was, nevertheless, incumbent upon the petitioner to produce the record of the Board of Medical Examiners before the court would consider any questions of fact.

The court properly refused to determine the issue, whether or not petitioner's license should be cancelled, as if no hearing had been had before the Board of Medical Examiners. Upon petitioner's refusal to place the Board's record before the court, the application for a writ of mandamus was denied and the order revoking petitioner's license stood unaffected.

The result of the court's decision is to require any person taking into the courts the propriety of disciplinary action by the State Board of Medical Examiners to introduce the record of the Board's proceedings before the court and then prove by a preponderance of the evidence that the decision of the Board was unreasonable and unjust as to him.

LETTERS†

Concerning Incidence of Poliomyelitis in California:

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH

San Francisco, California,
June 18, 1943.

Dear Doctor Gilman:

In line with our conversation on Friday, I am sending you a statement relative to the incidence of poliomyelitis in California.

The following tabulation will give you comparative figures for certain epidemic years and for the last five years:

	Cases Total to Mid-June	Cases Total for Year
1927	134	1,298
1930	336	1,903
1934	1,615	3,396
1939	94	973
1940	168	440
1941	75	237
1942	40	331
1943	203	.....

From the course of the disease thus far, it would appear that there would be a considerable increase over the last two years but that the epidemic will not assume the proportions of 1934.

Nobody as yet has been able to tell us how poliomyelitis spreads, but it is generally agreed that prompt reporting, proper segregation of cases, and, more recently, treatment by the "Kenny method," are factors of great importance. There is also a great feeling that exhaustion, undue exposure, and possibly depletion from other causes may be factors in the occurrence of the disease.

The State Department of Public Health has recently circularized the various local communities relative to the number of nurses, doctors, and physiotherapists who have had training in the "Kenny method" of treatment. The number is greater than I had anticipated, and is as follows:

Total Trained M. D.'s	17
Total trained physical therapy technicians	55
Total trained nurses	44

These individuals are giving excellent service in the treatment of cases which are occurring. There are not, however, sufficient to give proper care in the case of a large epidemic, and the Department is taking steps to increase the number of individuals who have had this training.

Sincerely yours,

(Signed) WILTON L. HALVERSON, M. D.
Director of Public Health.

The list which follows indicates the number of cases by counties:

Alameda	10
Contra Costa	5
Fresno	7
Kern	20
Los Angeles	90
Madera	2
Marin	1
Napa	1
Nevada	1
Orange	18
Sacramento	1
San Bernardino	9
San Diego	8
San Francisco	8
San Joaquin	3
San Luis Obispo	2
San Mateo	2
Santa Barbara	1
Santa Clara	6
Santa Cruz	3
Shasta	1
Solano	2
Tehama	1
Ventura	1
Total	203

(See also items on pp. 130-131.)

* * *

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

June 7, 1943.

To the Editor:—A recent study of meningococcus meningitis cases at the San Francisco Hospital during this calendar year has revealed an interesting observation.

As a part of the routine necessary before cases are discharged, a nasopharyngeal culture is taken on each case. This is a difficult procedure requiring accurate technique, the laboratory culture material is expensive, and, of course, it involves the time of skilled technicians.

In the study recently completed, it was shown that we have taken eighty-eight nasopharyngeal cultures on forty-four patients since January 1, 1943. No positive cultures have been reported to date.

Inasmuch as nearly all of our patients at the present time have been given sulfonamide therapy, the question arises that perhaps the use of sulfonamides precludes the possibility of a convalescent carrier state.

In view of the statistics of our experience in taking these cultures, we are at this time discontinuing taking nasopharyngeal cultures as a routine procedure before the discharge of these patients.

Sincerely,
J. C. GEIGER, M. D.,
Director.

* * *

Precautions for Polio

"More than the Usual Number" of Cases Reported Here

With "more than the usual number" of infantile paralysis cases currently reported in San Francisco, Dr. J. C. Geiger, health director, today listed precautionary steps to avoid spread of the disease.

At the same time the State Department of Public Health said thirteen new cases have been reported in the northern California area, bringing the total to twenty-eight for the week ending July 3. Eleven were in Sonoma County and one each in Alameda and San Mateo counties.

Precautions Listed

Doctor Geiger, who said San Francisco had five polio cases in May, four in June and one reported thus far in July, listed these precautions:

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

1. Thoroughly investigate even a slight illness.
2. Avoid exposure, especially by keeping children from new groups of people.
3. See that children put no soiled objects into their mouths.
4. Swimming may be an important factor in spread of the disease through contaminated water.
5. All cases and suspected cases should be promptly reported to the health officer.

Symptoms of Disease

Doctor Geiger said symptoms accompanying the onset of the disease are "many and varied." Usually present are a moderate degree of fever and the signs of a digestive upset headache, pain and stiffness of the neck and muscle tenderness.

As a rule there is a short period of from one to five days after the acute symptoms subside when the patient may be apparently well, he said. Then, if paralysis is to occur, muscle weakness may be noticeable. Pain in the affected muscles generally precedes paralysis and is a "very valuable sign" if recognized early.

He pointed out that physicians at Stanford, California, Children's and San Francisco hospitals have been trained in the Kenny method, adding that a number of out-of-town cases have been brought here for treatment.

Concerning Medical Publications Sent to Military Camps in California by the California Medical Association Postgraduate Committee:

(COPY)

STATION HOSPITAL
VICTORVILLE ARMY AIR FIELD
VICTORVILLE, CALIFORNIA

3 July, 1943.

California Medical Association
Postgraduate Committee
450 Sutter Building,
San Francisco, California.

Gentlemen:

We wish to take this opportunity to express our appreciation for the medical literature received by this hospital a few days ago.

It has been placed in our library, where it is easily obtainable by the members of the staff. Although it has only been at their disposal a short time, they have found the journals to be very helpful, and I am certain they will continue to find the material even more so, in the future.

The staff members of this hospital join me in expressing our gratitude for your contribution.

For the surgeon:

SAMUEL R. FERRIS,
2nd Lt., M. A. C.,
Executive Officer.

* * *

(COPY)

MEDICAL DEPARTMENT
UNITED STATES NAVAL AIR STATION
SAN DIEGO, CALIFORNIA

June 30, 1943.

California Medical Association
Postgraduate Committee
450 Sutter Street
San Francisco, California

Gentlemen:

The medical literature mentioned in your letter of June 21, 1943, has been received and will be distributed to our outlying air fields.

Your thoughtfulness in sending these journals is greatly appreciated and wish to thank you at this time.

Very truly yours,

L. E. MUELLER,
Captain (M.C.), U. S. Navy,
Senior Medical Officer.

Concerning a Hospital Staff Regulation Limiting Surgical Procedures of Staff Members:

(COPY)

San Francisco, June 9, 1943.

Dear Doctor ———:

Doctor Kress has forwarded to me a copy of your letter of June 1, 1943, in which you request my opinion with respect to the legal status of a physician on the staff of a private hospital.

The general rule of law is that any hospital may, by appropriate rules and regulations, restrict the practice therein in such manner as it sees fit, provided only that each particular rule or regulation must be reasonable and not arbitrary. For example, a rule of a private hospital restricting surgery therein to physicians and surgeons residing withing ten miles of the hospital would stand or fall, so far as the law is concerned, on the question as to whether residence within ten miles was a reasonable or an arbitrary requirement.

The question which you raise in your letter is within this principle of law and the proper answer to it depends upon whether the rule established by the hospital is reasonable or unreasonable. Of course, the question of reasonableness is not one that I can answer, as it requires a professional knowledge which no one other than a physician possesses. It is my understanding that the State Association has taken no stand with respect to the particular problem raised in your letter.

Therefore, it would appear that the matter is one of local jurisdiction and that the Los Angeles County Medical Society is the proper body to reach a decision in the first instance.

Very truly yours,

(Signed) HARTLEY F. PEART.

cc: Dr. George H. Kress, Secretary
California Medical Association.

MEDICAL EPONYM

Riggs's Disease

A paper read before the American Academy of Dental Surgery in New York on October 20, 1875, by John W. Riggs (1810-1885), M.D., F.A.A., D.S., of Hartford, Connecticut, entitled "Suppurative Inflammation of the Gums and Absorption of the Gums and Alveola [*sic*] Process," has served to attach his name to the condition of pyorrhea. This appeared in the *Pennsylvania Journal of Dental Science* (3:99-104, 1876). A portion of the text follows:

"This disease is called by many the disease of old age . . . but at the present day we find the middle aged, and even the young, affected by it . . . one by one the teeth become loose from loss of bony support and are plucked out as an intolerable annoyance. If the inflammatory action be great and involve most or all the gum embracing the teeth, pus tinged with blood exudes from around the necks of the teeth on the slightest pressure of the lips or tongue, or in mastication. The oral secretions become vitiated, present a viscid or sanious character, very abundant in quantity during the day, but much more so in the recumbent position of sleep. If the patient reposes on his side these exudations flow out of the corner of the mouth over the pillow and present in the morning a dried, yellow discoloration, often tinged with blood and covering a space as large as one's hand. If the patient reclines on his back the diseased mass flows back into the fauces and is unconsciously swallowed, then to work a greater mischief. . . . None but the most vigorous constitutions can withstand this type of disease."—R.W.B., in *New England Journal of Medicine.*

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 8, August, 1918

EXCERPTS FROM EDITORIAL NOTES

Venereal Disease.—It is important that the American nonmedical public be shaken out of its false modesty regarding venereal disease. This object is being attained to a remarkable degree as a result of the Army and Navy policy combined with the work of the Commission on Training Camp Activities. We are being forced, as a nation, to take a sane and scientific attitude toward the subject. Syphilis and gonorrhea constitute one of our chief sanitary and public health problems. . . .

Universal Service.—Every patriotic American believes today in universal service as a war measure. This, in the broad sense, simply means complete and efficient organization and mobilization for war of all the resources of the country, both human and material. It means "work or fight" for men in draft age. It means suppression of nonessential activities of all sorts. It means for each man and woman to get the maximum physical efficiency personally. It means a conscious development of individual patriotism. It means intelligent and constructive study of our personal and national ideals. It means scrutiny of national problems and policies. It means informed interest in politics, in social activities of relief and charity, in local and general social problems of civics, morals, religion, and health. It means, in short, a literal reading of the words *universal* service, making every person contribute his utmost to himself and his fellows in the way of physical, intellectual, and moral improvement. *That* is universal service. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Prevention of Blindness Work of the State Industrial Accident Commission," by Will J. French, San Francisco.—The earliest reference to "Safety First" I have been able to find is in Chapter 22, verse 8, of Deuteronomy, the fifth book of Moses, where these words appear: "When thou buildest a new house, then thou shalt make a battlement for thy roof, that thou bring not blood upon thine house, if any man fall from thence."

The foundation of English common law is taken from the five books of Moses, from Genesis to Deuteronomy, and we can there read much that represents the highest ideals of present-day civilization. If they had used emery wheels in those day, I think we would be able to read a verse following the one quoted about like this: "When thou grindest tools on the emery wheel, then thou shalt use a hood over the wheel and goggles over thine eyes that thou bring not blindness upon thine house because of dust entering the windows of thy soul."

The National Safety Council estimates there is one worker killed every fifteen minutes, day and night, in the United States, and one injured every sixteen seconds, day and night. This gives us more than 30,000 killed and about 2,000,000 injured. It is estimated that out of this number there are 200,000 eye injuries. . . .

From an Article on "A Plea for a Complete Urological Diagnosis at One Sitting" (Preliminary Communication), by Martin Krotoszyner, M. D., and George W. Hartman, M. D., San Francisco.—In a recent comprehensive treatise,

(Continued on Back Advertising Section, Page 32)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.
Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners was held in San Francisco, June 28 to July 1, 1943, at which time written examinations were conducted for physicians and surgeons, drugless practitioners, and chiropodists. One hundred and thirteen physicians and surgeons, one drugless practitioner, and five chiropodists presented themselves for examination at this meeting.

Legal hearings were conducted by the Board on charges of unprofessional conduct. The following changes were made in the status of licentiates:

Atkinson, John Ames, D. P. (Alleged violation of probation.) On June 30, 1943, Doctor Atkinson was placed on probation for five years, with suspension of license ordered to take effect for one year from July 10, 1943, or if court action taken, then suspension to start ten days after the date of termination of such court action.

Glaeser, William E., M. D. (Alleged illegal operation.) On June 29, 1943, found guilty and license revoked.

Koerber, Lillie Louise, M. D. (Alleged illegal operation.) On June 30, 1943, found guilty and license revoked. Doctor Koerber was granted a stay of execution to and including July 10, 1943.

Weaver, Darrington, M. D. (Record of conviction.) On June 28, 1943, found guilty and his certificate revoked.

The regular meeting of the Board of Medical Examiners was held at the Elks Club, Los Angeles, August 9 to 12, 1943, at which written examinations, legal hearings, and other administrative business were conducted.

News

"Drugless practitioners may legally sign death certificates, according to an opinion released today by Attorney-General Robert W. Kenny. Kenny's opinion was given to the Board of Medical Examiners. Kenny pointed out that the courts of this State had never ruled on the legality of the question. 'In thus making it possible for the drugless practitioner to sign death certificates,' Kenny wrote, 'it should of course be realized that the implication is not to be conveyed that such drugless practitioners may call themselves or advertise themselves as "physicians," or that they may practice "medicine." A drugless practitioner receives his license from the Board of Medical Examiners,' wrote Kenny. 'By law, the mode of treatment of human diseases, injuries and deformities employed by drugless practitioners is recognized. It is difficult for me to believe,' Kenny stated, 'that a drugless practitioner in attendance on such a patient should not be qualified to file the certificate of death as well as the medical certificate.'" (Chico *Enterprise*, June 23, 1943.)

"Attorney-General Robert W. Kenny declared today in an opinion to the State Board of Medical Examiners that the law which prohibits wholesale manufacturers or distributors of lenses and optical supplies from acting as dispensing opticians or optometrists to be unconstitutional on the ground that it is discriminatory. (San Francisco *Call-Bulletin*, June 30, 1943.)

(Continued in Back Advertising Section, Page 45)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.